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REDUCING INAPPROPRIATE MEDICARE SPENDING

HEARING

BEFORE THE

SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE UNITED STATES SENATE

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SECOND SESSION

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REDUCING INAPPROPRIATE MEDICARE SPENDING

THURSDAY, MAY 21, 1992

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:06 p.m. in room SD–215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Also present: Senators Daschle, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H–26, May 14, 1992]

SUBCOMMITTEE TO EXAMINE WAYS TO CUT INAPPROPRIATE MEDICARE SPENDING, ROCKEFELLER SAYS STRICTER OVERSIGHT NEEDED

WASHINGTON, DC.—Senator John D. Rockefeller IV, Chairman of the Senate Finance Subcommittee on Medicare and Long-term Care, Thursday announced a hearing to look at ways to reduce inappropriate Medicare spending.

The hearing will be at *2 p.m. Thursday, May 21, 1992* in SD–215 of the Dirksen Senate Office Building.

Rockefeller (D., West Virginia) said the Subcommittee will explore ways to reduce expenditures through more rigorous oversight of waste, fraud and abuse in the Medicare program.

"The Subcommittee will assess issues relating to funding of intermediaries and carriers for oversight activities and will address the provision of unnecessary services," Rockefeller said.

Senator ROCKEFELLER. This hearing will come to order. The junior Senator from West Virginia appears to be late, and in my guilt would ask, and Dave Durenberger said it is all right, that Senator Cohen proceed so that we can make sure that you have a chance to speak before the vote, and then we can make our comments afterwards.

STATEMENT OF HON. WILLIAM S. COHEN, A U.S. SENATOR FROM MAINE

Senator COHEN. I appreciate that very much, Mr. Chairman. Thank you for inviting me to testify at this afternoon's hearing to examine the ways in which we might better protect Medicare from fraud, abuse, and inappropriate spending.

As all of us in this room, know, our health care bill is expected to top $817 billion this year. And, unfortunately, this explosion in health care spending has also created a literal wealth of opportunities for a growing and increasingly sophisticated army of "scam art-

ists" who have embarked on a spree of what one regulator has called "white collar wilding."

As our Nation's largest payer for health care— and as the fastest growing major program in the Federal budget, Medicare has become a prime target for looters and larcenists looking for ways to make a quick million or two off the system.

While the overwhelming majority of the Medicare providers are dedicated and honest professionals, the rapid growth and sheer size of the program has greatly increased Medicare's vulnerability to fraud and abuse.

Therefore, we have to be extremely vigilant in our efforts to ensure that sufficient safeguards are in place to detect and eliminate the corrupt few who are robbing the taxpayers by billing for services and supplies that are unnecessary, inappropriate, or, indeed, even of inferior quality.

Last fall, the Senate Aging Committee held a hearing which focused on the problems and potential for fraud and abuse in the current system used to issue provider numbers to those who wish to bill Medicare for their services.

Currently, Medicare carriers are responsible for assigning provider numbers to hospitals, physicians, home health agencies, and medical supply companies who plan to bill Medicare for their services.

But most carriers do not keep track of their providers, and the numbers are rarely deactivated, even when the provider has lost the legal authority to practice.

This lack of carrier oversight also enables those providers to be issued multiple numbers, allowing them to double bill, over bill, and then avoid being caught for these fraudulent activities simply by hopping from one number back to the other, and thereby covering their tracks.

The provider number system is even more lax for medical equipment suppliers. Durable medical equipment suppliers are not required to be certified or licensed in order to do business with Medicare. In fact, they do not have to meet any standards whatsoever. The carrier will issue a number to any supplier requesting one, no questions asked.

In my estimation, the current system is the equivalent of the government issuing a lifetime gold card with an unlimited balance and no annual service fee to suppliers without first running a credit check.

Last year, the minority staff of the Aging Committee conducted an investigation of durable medical equipment telemarketers who were taking full advantage of the current weaknesses in the system in order to bleed millions of dollars from the Medicare program.

Our investigation revealed some rather shocking practices of fly-by-night operations that made call after call to unsuspecting seniors to induce them to accept what was described as "free medical equipment," equipment that was rarely needed, generally of inferior quality, and of little or no therapeutic value.

And I will give the committee just a few examples. A plain piece of beige foam cost one DME supplier $23. It was billed to Medicare for more than $240 as a flotation pad for a wheelchair.

A simple heating pad which could be purchased through a Sears Catalog for $23 was purchased by a DME telemarketer for $9.68. They then billed Medicare for $67, which was three times the price at Sears, and nine times the original purchase price.

And, finally, a bed-sized, flimsy piece of pink foam was billed to Medicare as a dry flotation mattress to prevent bedsores.

This item, which is next to useless—I do not think it even qualifies as being useless—was purchased by a supplier for about $28. It was billed to Medicare for more than $1,100, which represented a profit of more than 3,800 percent.

In the wake of these exposures, I introduced legislation, the Quality Medical Equipment and Supplies Act, which takes several steps to guard against unscrupulous providers.

It would require suppliers to meet strict criteria and disclosure requirements in order to obtain and renew provider numbers; it would require HCFA to develop a standard provider number application form and require suppliers to certify the accuracy of the information they provide; it would call for the verification of the information given by providers through random audits and on-site inspections; it would call for uniform coverage and utilization criteria so all carriers will be paying the same reimbursement rates for items under the same circumstances.

And the bill also includes provisions to encourage HCFA to consider the quality of items billed to Medicare to discourage suppliers from selling inferior, and sometimes even dangerous equipment to Medicare beneficiaries.

Mr. Chairman, I am abbreviating my comments in view of the fact that we do have a vote that is coming up. But I want to indicate to the committee that my staff and I are willing to work with this committee. There are a number of proposals pending which have a similar objective.

HCFA has proposed tighter regulations for DME supplies. Some will ask the question, why legislation, if HCFA is prepared to do it through the regulatory system?

The answer is, because HCFA has not been diligent enough in the past. I do not believe the regulations go far enough, and I think legislation is called for.

Another question that may be asked, perhaps. What about the cost of this legislation, or perhaps comparable legislation? I have not had an opportunity to have CBO actually come up with an official estimate.

But Don Muse, who, formerly, I believe, worked for the Finance staff and with CBO, is now a private consultant and has indicated that this legislation would save Medicare between $35–$40 million annually, or about $170 million over a 5-year period. I commend it to your consideration.

[The prepared statement of Senator Cohen appears in the appendix.]

Senator ROCKEFELLER. Thank you, Senator Cohen. You also, do you not, prohibit physicians from referring patients to——

Senator COHEN. Another provision would prohibit physicians from referring their patients to a DME supplier in which they or a relative have any kind of an economic interest.

Senator ROCKEFELLER. I just thoroughly commend you for this. One of the interesting things about the Senate and how little we see each other and get to talk with each other, although we are in the same buildings all day long, is I had not, until preparing for this, realized how effectively, and how hard, and productively you have worked on this. What was it that sort of piqued your interest or caught your interest, and how far back did that go?

Senator COHEN. Well, it goes back to 1975 when I first served on the Aging Committee in the House of Representatives. And Senator John Heinz and I were the initial members, joining Claude Pepper, who was Chairman of the Aging Committee in the House. Since that time, Senator Heinz and I have worked closely together, and this was actually something that he initiated prior to his death.

With the loss of Jack Heinz, I moved up to become the Ranking Member and took over the completion of this investigation.

As a matter of fact, the day that he died he was on his way to attend a hearing in Pennsylvania dealing with this issue.

Senator ROCKEFELLER. On this? That was the hearing?

Senator COHEN. Right.

Senator ROCKEFELLER. That is interesting. Well, you are really excellent about it. It is my own ignorance that has not followed, which is part of our problem here. We do not communicate enough; even committees do not communicate enough.

And I think, Senator Durenberger, even on this committee, we have not paid enough attention to our oversight function, and there are various reasons for that which I will not get into now. But I really respect what you have done. It is real, it is long-term, and it has been very helpful. I am very grateful that you took the time to come.

Senator COHEN. The examples are truly shocking when we see photographs of rioters and looters, and we are justifiably outraged by the sight.

Nonetheless, this is the moral equivalent, to say the least, that we have white collar criminals who are doing exactly the same to the taxpayers of this country. It may involve less violence, but is doing great violence to the system. And it is also depriving people who are in desperate need of these services and equipment of what they need.

Senator ROCKEFELLER. And it is not at random, it is calculated.

Senator COHEN. It is very calculated.

Senator ROCKEFELLER. Senator Durenberger.

Senator DURENBERGER. Well, Mr. Chairman, first, thank you for holding this hearing. I do not think we have done this before. I think it was a few months ago you held the very first hearing we ever had on medical liability and malpractice in this committee. I do not recall spending a lot of time in the 13–14 years that I have been here looking at what is wrong with the system, except when Jack Heinz would pull our cord. So, medical device manufacturers got called in here once in a while.

It all began with the commitment that all of you had who have been with the Aging Committee for a long time. I appreciate the Chairman's question and the attribution to Jack Heinz, because he could think about the bigger picture and he could move us where

we ought to be 5 or 10 years from now. At the same time, he had the gift of being able to deal with the unfairness that was occurring in the current system.

The buzzer just went off for the first vote, so I will not take a lot of time. But let me make an observation about the way in which we price access to the current system.

One of the things that makes it so difficult for those of us who believe we are dealing in a dysfunctional health marketplace—that if we could just figure out the dysfunction and eliminate it we could make this market work—is that everywhere you go you find the market ripping somebody off.

From my observation, I think the reality is if you do not set appropriate rules and you do not get the consumer involved in this thing, to do the consumer's normal function, which is to assess quality and relate that quality and value to a specific price, you are going to have problems.

One of the things we have done in this society is insulate people from any role in these decisions. So, no wonder they and we are so easily ripped off by the system.

Senator COHEN. Well, you have a situation in which people sit back. As Chairman Rockefeller has indicated, it is not at all random, it is quite calculated. They take a survey. Where are those regions which provide for the highest reimbursement?

And they will move into there, set up a boiler shop, take teenaged kids out of school, set them up with a telephone, a phone book, a list of all the senior citizens, and just start calling them persistently, saying, you are entitled to the following, and it is free of charge, which, of course, it has not. But, nonetheless, it has been sold in that manner. And then that puts the pressure upon the senior citizen who then calls the doctor and says, well, I am entitled to this, why can I not have it?

And then you have a system where the doctors do not have time or the inclination to deny it because they do not want the aggravation or the grief to think that they are denying something to a patient that that patient feels he or she is entitled to.

So, then as the system just starts to get under way and feeds upon itself, and then these particular individuals will then look for which carriers provider the greatest benefits.

Some might not provider certain types of services or equipment, so they move on to a different area. And it is all quite calculated. It is totally destructive. It is practiced by a few as opposed to the many, and it is something we have got to deal with, I think, in a very serious fashion.

I also would point out that with this legislation, that what we have to do, I think, is exercise much greater oversight. And that entails something that we are not prepared to deal with right now. All of us rail against too much regulation, too detailed regulation.

You have heard me take the Senate Floor and complain about a regulation or description in the Federal Register which lists 14 pages for the Department of Defense describing what a cookie is. And I have taken to the Floor to ridicule the excessive amount of detail in the regulations.

We have just the opposite here. So, a flotation pad could be anything. A piece of foam suddenly qualifies as a flotation pad, in

which you can spend $1,100 for something that costs a few cents. So, we have got to get much more descriptive.

And one of the provisions in my legislation would require the Secretary of HHS to actually show the medical requirement and quality involved in the reimbursement rates so that we know what we are paying for.

That means getting more detail into the description of the devices that we are reimbursed for. But we cannot go so far to the other extremity, as such, to become so burdensome that it becomes unenforceable at the other end.

So, I think we have got a lot of work to do. HCFA can be very helpful, but I do believe that we need legislation, and not simply leave it up to the regulators.

Senator ROCKEFELLER. Senator Cohen, thank you very much. We shall go vote, and the hearing will be in recess for just a few moments.

[Whereupon, the hearing was recessed at 2:20 p.m.]

AFTER RECESS

Senator ROCKEFELLER. The hearing will resume. Mr. Toby, if you will forgive me, I just want to make a brief statement. I am sorry. We had two votes, not one vote.

And everybody is rushing to the Floor to describe how quickly and how anxious they are to put looters, specifically in California, specifically the recent California situation, to death.

So, there is just an endless number of death penalty amendments which are tacked onto everything in sight. So, it is an interesting time.

David, I am just going to give my comments on this.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA, CHAIRMAN OF THE SUBCOMMITTEE

Senator ROCKEFELLER. I indicated some frustration at the beginning because, in the Finance Committee, we do not seem to be very aggressively systemically in terms of oversight, and that bothers me. But that is something for a later discussion.

The subject that we are looking at, waste, fraud, and abuse, are those perfectly wonderful things that one talks about. Everybody has very simple thoughts, gets very angry, and wants to do something drastic.

But, in reality, this question of waste, fraud, and abuse is very difficult, raises a lot of very difficult issues, very difficult questions. But it will be our focus, because it is a substantial one.

We are told that waste, fraud, and abuse in Medicare is costing taxpayers billions of dollars and it hurts everyone who is involved in the program, from carriers to intermediaries, administrators to providers, and, most importantly, of course, millions of Medicare beneficiaries themselves, not to speak of the American taxpayer.

It also undermines the public's confidence in our ability to do something generally about comprehensive health care reform in this country. That is a very major fact that Senator Durenberger and I both understand, that people understand that the govern-

ment needs to do something, but, on the other hand, they do not have much confidence in something called the Federal Government.

So, they want us to do something but they do not have much confidence in the way we might do it, so, hence, an endless stalemate. Medicare, obviously, is one of the largest and fastest growing portions of the Federal budget.

I cannot keep up with its numerical climb, myself. Although we have slowed the annual rate of growth in real spending per enrollee from 7.3 percent a year between 1980 and 1985, it is now down to 3.1 percent since 1985, nevertheless, the Medicare program will require $145 billion in spending for this year that we are in.

Pressure to reduce the Federal deficit has led to proposals like arbitrarily capping Medicare. The problem I see is that capping Medicare without controlling the costs in the private sector will just mean more cost shifting.

And that, of course, has to do with the architecture of broader health care reform, which, in a sense, if you produce more cost shifting, it is just like suppressing the symptoms without curing the disease. Nevertheless, people will want to take a look at that, also.

To reduce further growth in health care costs, we need comprehensive reform. We have to have it. We just cannot stand apart on that. We do not want to resort to taking out a machete against the country's most vulnerable people, but, on the other hand, it is also clear that part of reform must be to wring out the waste, the fraud, and the abuse in Medicare and our entire health care system.

We cannot continue to allow Medicare funds to be squandered carelessly, if that is what is happening, because of misplaced priorities, which we will question today, or misdirected payments, or unchecked fraud, or flat-out abuse.

It is time to put the spotlight on these problems and to start deciding what action needs to be taken and what action might wisely be taken. My hope is that we will think both specifically and that we will, indeed, try to think broadly.

If major systematic change should be considered, we should be prepared to consider it. And we need to identify a variety of more surgical steps that could save money and free up resources for better uses, including deficit reduction.

Today we will hear from people who say they want to help crack down on the waste, fraud, and abuse in Medicare: the Acting Administrator of the Health Care Financing Administration, Bill Toby, is one, and he is before us now; the General Accounting Office, and the Office of the Inspector General will testify that we can, in fact, save billions of dollars with better payment safeguards. We will need to get their help in mapping out the precise way to do all of this.

The durable medical equipment industry will serve as an instructive example of a segment of the Medicare program where abuse has, in fact, been identified, and where work has begun to eliminate that abuse.

Providers from the durable medical equipment, both the Coalition for Quality Home Medical Equipment and Supplies, and also

the National Association of Medical Equipment Suppliers, NAMES, as it is called, will discuss the effects of past and pending regulatory efforts on their industry, with special regard to Senator Sasser's Durable Medical Equipment Patient Protection Act.

We will have the benefit of the expertise of two Medicare contractors, one representing Blue Cross and Blue Shield, another a medical director testifying on behalf of Transamerica Occidental Life.

They will discuss the difficulties of processing more than, if you can believe it, more than 700 million claims and the potential for using innovations to eliminate mistaken Medicare payments.

I hope this hearing will demonstrate that we have not given our investigative agencies the resources that they need to hunt down fraud and abuse. I have joined Senator Biden and others in addressing a bill which is the Health Care Prosecution Act of 1992.

It is interesting, the titles that we give bills, is it not? They all sound like you just pass it and solve all of our problems in one fell swoop.

Senator DURENBERGER. It sounds like amendments on the floor.

Senator ROCKEFELLER. Exactly. And I was discussing that, Senator, just before you came in. And it would, in turn, increase penalties, more FBI agents, Federal prosecutors, and require mandatory resolution.

The theory, less is more, does not necessarily apply to the oversight of the Medicare program. Funding for safeguard activities decreased significantly from 1989 to 1991, despite the fact—and this is stunning—that $14 are in fact returned for every one dollar spent on Medicare safeguard activities.

People need to understand that. People talk about Head Start. Every one dollar you spend, four dollars is saved. Here we are talking about every one dollar you spend, $14 is saved. I have never heard of such an effective ratio of return.

Several members of Congress want to earmark a portion of the dollars recovered by safeguard activities for more recovery. Senator Grassley, who will be here, I believe, has introduced legislation which will remove Medicare payment safeguards from the discretionary budget spending caps. It sounds like we should give his legislation very serious consideration, insofar as I am concerned.

But, first, Medicare oversight activities must be clearly defined. We will have to have confidence that HCFA will maintain proper supervision of its contractors.

We must work together, all of us, to find effective ways to reduce the deficit by ensuring that taxpayer dollars are spent wisely and are returned when appropriate.

Effective Medicare payment safeguards will go a long way towards ensuring that this important program is operating at maximum efficiency.

So, I hope that this hearing will lay the ground work for very serious efforts that we will sustain our interest in to improve the program, to protect it much more from the scourges of the same waste, fraud, and abuse.

I thank you, Administrator Toby, for allowing me to proceed in that fashion. I welcome both of you. And I understand also very well that you are new to the job—not new to the field, but new to this specific job—and you have a wonderful opportunity, it seems

to me, to talk to us very frankly and give us the advice of your very respected counsel. So, we will welcome your testimony. There will be 5 minute limitations. I notice that I did not put one on myself, and I apologize for that.

STATEMENT OF WILLIAM TOBY, JR., ACTING ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC, ACCOMPANIED BY BARBARA GAGEL, DIRECTOR, BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Mr. TOBY. Mr. Chairman and members of the subcommittee, first, I want to thank you for recognizing I am new to Washington.

I am pleased to be here today to discuss our efforts to safeguard the Medicare Trust Funds from improper payments for services and supplies.

With me today is Barbara Gagel, who is Director of the Bureau of Program Operations, which has responsibility for contractor activities.

The Medicare program actively pursues activities to ensure proper payment for necessary services. Today I would like to focus on two major areas: the Department's durable medical equipment initiative, and Medicare contractor payment safeguard activities.

Last November, the Secretary announced the Department's DME initiative. The initiative comprises a comprehensive program of regulatory, administrative, and legislative improvements to curb fraud and abuse, and set more reasonable payment levels for DME supplies nationally. In fact, many of the reforms being discussed in pending legislation are already being discussed as part of our DME initiative.

Our final regulation will be published by the end of the month. The final rule will establish four regional carriers to process DME claims. It will also set tight controls on the issuance of billing numbers and require suppliers to meet standards for good operating practice.

The regulation will close the loophole that makes it easy for suppliers to game the system by shopping for carriers that pay the highest rates for equipment or supplies. Suppliers now will be paid based on the rates set where the beneficiary resides.

We are aggressively pursuing a number of administrative activities to curb abusive DME market behavior, including increasing the consistency of medical review for frequently used or abused DME, developing standard requirements for certificate of medical necessity forms, and educating physicians and beneficiaries about abusive DME practices.

Finally, we have several DME legislative proposals aimed at standardizing payments for DME and other medical supplies nationally, and for curbing fraud and abuse. We look forward to our continued work with you and other members of Congress to put the system on the right track.

From a broader perspective, Medicare is aggressively moving to combat incorrect and unnecessary payments. Medicare contractors serve as our front-line defense to protect the integrity of the trust funds.

Contractors carry out four ongoing payment safeguard functions: medical and utilization review; fraud and abuse detection; provider audits; and the MSP program, which is Medicare Secondary Payer.

Every dollar spent on contractor payment safeguard activities, we believe, is a good investment. We expect each dollar devoted to payment safeguards will yield a $15 return to the trust funds, for a total of $6.2 billion in fiscal year 1993. The administration is committed to properly funding payment safeguard activities, and improving the efficiency of contractor performance as well.

Even within tight budget constraints, the President's fiscal year 1993 budget request of $404 million for contractor payment safeguard activities is nearly 18 percent above the 1992 budget.

One major payment safeguard function is determining that services billed are medically necessary and appropriate. We are restructuring utilization review policies to be more efficient, while minimizing the hassle in the utilization review activities.

We also believe that Medicare beneficiaries play an important role in detecting fraud and abuse. They often inquire about questionable billings and payments reflected in the Explanation of Medicare Benefits form from the carriers. We recently revised the EOMB form to make it easier for beneficiaries to understand and to identify incorrect Medicare payments for services.

Carriers begin investigation as soon as possible following receipt of a complaint identifying a case of a potential fraud or abuse.

I also want to mention another important safeguard area for us is the auditing of cost reports for hospitals, home health agencies, and skilled nursing facilities.

The fiscal year 1993 budget request was $150 million for provider audits. We expect to save $1.8 billion in 1993 for a return of $12 for every dollar invested.

The final payment safeguard function is the Medicare Secondary Payer Program. The Medicare program, by law, cannot pay for service, covered by other insurance plans. There are two things I would like to say about it.

One, is that our secondary payer efforts are being enhanced by the implementation of the Internal Revenue Service, Social Security Administration, and HCFA data match.

That match will be especially helpful in identifying secondary payer cases resulting from spouses with health insurance through employment. We expect to start recovering funds this summer as part of the data match project.

The President's budget includes $82 million for Medicare secondary payer activities. Here, we expect a return on our investment of 58 to one for Medicare Part A, and 18 to one for Part B. Total secondary payer savings are expected to be approximately $3 billion in 1993.

So, in total, the President's fiscal year 1993 budget request for Medicare contractors is $1,664,000,000. The budget request assumes enactment of four legislative proposals that would save $89 million. Perhaps I should stop there.

Senator ROCKEFELLER. No. You can proceed if you want.

Mr. TOBY. All right. One proposal would pay claims submitted electronically faster than paper claims. That is one of our legislative proposals. Another proposal would allow the Secretary to reas-

sign fiscal intermediary functions from a substandard performer to another fiscal intermediary.

And we also propose to eliminate reward payments to contractors for increasing participating physicians. The final legislative proposal would cap contractor cost reimbursement at the 60th percentile of all contractors.

These four legislative proposals would give us the firm authority and funding to respond to the rapidly increasing cost of processing claims.

We believe we have a strong program in place for protecting the Medicare trust funds from inappropriate and unnecessary payments. We recognize that improvements can always be made, and enactment of our legislative initiatives for DME and contractor reform would aid our efforts, as well.

We look forward to working with you in the future. Thank you. I will be happy to answer any questions you may have.

[The prepared statement of Mr. Toby appears in the appendix.]

Senator ROCKEFELLER. Thank you, Mr. Toby. Senator Durenberger, did you have any comments you wanted to make? I think you were out of the room when I finished.

Senator DURENBERGER. Mr. Chairman, thank you. I regret that, but I was trying to make a telephone connection.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. I will make a brief comment and ask that my statement be made a part of the record.

[The prepared statement of Senator Durenberger appears in the appendix.]

I concluded my statement in the record with the following observation: That one of the benefits of using diagnosis-related groups or other forms of encapsulated payment systems is also one of the benefits of moving in the direction of capitated funding. That is, it makes fraud and abuse a lot harder to get away with in this program of ours.

I also wanted to make the observation that one of the problems with the American system is that we get exactly what we pay for, and that is an awful lot more services than we need in our society.

We should not be surprised if some of those have inflated prices on them because we operate also on the theory that the more you pay, the more you get.

I would also like to make the observation that good, efficient, high-value providers of medical service in this country are not rewarded by getting more business. In fact, usually just the opposite is true.

Good providers—I think of industries that are often much maligned like durable medical equipment and so forth—are not rewarded for efficiencies and they see those who are ripping off the system in one way or another not being penalized. And that is a discouragement to good people in a system.

I think that if there is a failure in the American system, it is that while most of the providers of medical services and medical care would like to do right, there is not a standard for what right

really is. There is not a standard for what high quality is, and for what good value is.

So, unfortunately, those who take advantage of this system are the ones that set the impression that people have of everybody else in the business.

The last comment I would like to make in the larger context of health care reform—and everybody here in involved in one way or another in one of these approaches—is to caution those of my colleagues who advocate single-payer systems, particularly those that are sponsored by government. If you think it is bad now, wait till you see what happens when you enroll everybody in America with a single-payer system.

You do not do something about rewarding good providers for doing good things for people, and you do not set a high quality standard in this country that is rewarded more appropriately than the way we do it now. You are going to have nothing but trouble.

The value of these hearings is to tell us what is wrong with the way in which America rewards innovation and quality providers of medical care, not just to pick apart the inefficiencies of HCFA oversight or the greed which we know exists in any part of the system.

Perhaps it would be a spur to all of us who are involved in this reform movement to find ways to change the payment systems so that we do not have to sit here and go service by service and provider by provider and determine what works and what does not work, that that will be taken care of by the system itself.

Senator ROCKEFELLER. Thank you, Senator. I want to congratulate HCFA for what you have been doing on a continuing basis to try to reduce this whole question of waste, fraud, and abuse, particularly related to the DME situation.

Mr. Toby, when it comes to renting versus purchasing aspirators, nebulizers, wheelchairs, et cetera, I would be interested in your reasoning about which is more beneficial, purchasing or renting.

Mr. TOBY. I would like to start at another point. I heard Senator Cohen talk about the pricing earlier, and I was intrigued by what he had to say. I am one of the people who had been working in the field for years and I had deep concerns about the price we were paying for some DME items.

And I distinctly remember back in 1987 when we essentially lost the authority to set prices based on inherent reasonableness. I am sure you may remember that. When we lost that responsibility, we had to move to a fee schedule. Some of the things that Senator Cohen talked about, in fact, we could have priced better if we had better control.

One of our DME legislative proposals is asking to improve our authority to set prices based on inherent reasonableness.

If we get that authority, we will be able to set prices and get rid of some of the waste and the extraordinary abuses.

Senator ROCKEFELLER. Well, no. I appreciate and understand that. But, currently, as I understand it, a wheelchair has to be rented. And you want to, for example, see a wheelchair purchased, and that intrigues me as to your reasoning.

Mr. TOBY. Well, that is true. Barbara can talk about this more specifically.

Ms. GAGEL. As you know, Senator, whether or not equipment is rented or purchased, to a great extent, is laid out in the law in very broad categories. Wheelchairs is one category that seems to flip back and forth every 2 or 3 years in terms of whether or not it should be a purchase item or whether or not it should be a rental item.

And I do not think that, quite frankly, we have a good or a right answer to that, because a wheelchair is not a wheelchair is not a wheelchair. There are, as Senator Cohen indicated earlier today by way of example, literally hundreds of wheelchairs and attachments to wheelchairs that Medicare can pay for, all of which need to be priced separately.

We are always looking at whether or not it is in the best interest of the government to rent or to purchase equipment. For example we look at whether a chair should be purchased or rented; how long is it going to be used; and the extent of servicing that is going to be needed. All those things need to be taken into account in terms of whether or not a wheelchair should be rented or purchased.

Senator ROCKEFELLER. No. I understand all this. But tell me if my question is wrong. My assumption, what I understand, is that, whereas these things are being rented, as well as nebulizers and aspirators, and NAMES, for example, will say that wheelchairs should be purchasable. And my understanding was that Mr. Toby wanted to have them purchased as opposed to rented, and I am interested—I mean, do not take me through the complexities of a wheelchair. If I asked the wrong question, then tell me.

Ms. GAGEL. With regard to nebulizers and aspirators, yes, we are submitting a legislative proposal very shortly that would have them become purchase items.

The reason is that we have found nebulizers and aspirators are over-priced under the current price structure. They do not need to be frequently serviced, and we think a lot of money can be saved for the program if they become purchase items. It is my understanding that we will submit that proposal to you in the very near future.

Senator ROCKEFELLER. All right. You have told us—this is kind of targeted a little bit at OMB, just for your predisposition—that you are aggressively moving on all fronts to combat incorrect and unnecessary payments by Medicare contractors.

Yet, since November, you have canceled requirements that hospitals report quarterly their Medicare credit balances. And I understand that this reporting enabled you to identify millions of dollars of over-payments since Medicare was not the primary payer. Can you explain to me why you made this cancellation and if you are reconsidering, or whatever?

Ms. GAGEL. It was a temporary cancellation. Unfortunately, we had implemented a standard reporting system and, quite frankly, we just failed to go to OMB and get the approval of the form. OMB has now given us that approval and the reporting requirement was reinstated, I believe, 1 day this week.

So, it is back in. It was a temporary delay for us. During that period of time, a number of hospitals voluntarily sent in information to us and we recovered, I think, over $60 million during that

same period of time. In the end, no money will have been lost to the program because of the delay from November until now.

Senator ROCKEFELLER. All right. Historically, contractors have been given considerable discretion in setting and implementing payment and safeguard policies. You seem—and tell me if I am wrong—to be reversing this precedent by encouraging carriers to share automatic data processing systems which, therefore, reduces the number of carriers that handle DME claims. What is it, 34 you are trying to get it to?

Mr. TOBY. In our new regulation, there will be four regional carriers processing DME claims.

Senator ROCKEFELLER. And asking for legislation, in fact, to reassign fiscal intermediary functions to substandard work. How much should we preserve, or what integrity is there in the preservation of the autonomy, so to speak, of contractors?

Mr. TOBY. Although we have been moving substantially toward greater standardization and greater uniformity, there remains a great deal of autonomy with regard to contractors.

The Medicare program has been locally based for 27 years, where decisions on pricing, coverage, and medical necessity were all made by the contractor. Over the last 4 years we have been moving much more aggressively to improve administration through standardization and through consistency. We have left a lot of decisions at the local level especially with regard to coverage and medical necessity, because medical practices vary greatly.

We realize that there is still a need to move much more aggressively in terms of standardization and consistency because it is, indeed, a national program in the end.

In addition, if we are going to have a greater capacity to get rid of waste, fraud, and control abuse as well, we have to have much more consistency nationally.

Senator ROCKEFELLER. All right. My time is up. Senator Durenberger.

Senator DURENBERGER. Thank you very much. I just have a couple of questions. One, is whether or not funding and financing in the payment safeguards budget, is a problem for the agency?

Mr. TOBY. We believe that we all operate in a very difficult fiscal framework, Senator. But we have been working very closely with our contractors. And even though it has been very, very difficult in this fiscal climate, we have doubled the contractor budget since 1983.

I was intrigued by Senator Rockefeller's comment about the fact that Medicare contractor funding continues to increase. The Medicare contractor budget for 1989 to 1991 has increased $100 million each year—$100 million.

So, there is a lot of pressure on the budget, without question. But we find that even in this environment, we have been able to get the job done. In other words, what we have been forced to do is to prioritize the work.

We place a lot of priority on claims processing. That has been a first priority because of mandated timeframes; we have to get it done. We also have to do the appeals. I believe that even within the fiscal constraints, we have shown very clearly our commitment to payment safeguard activities.

So, we think, for the most part, that we have been able to get the job done within a tight budget framework, and we are comfortable that if our budget is passed this year, including the $404 million we requested and the legislative proposals we have put forward, we will be able to do very well this year.

We have requested an increase this year of 18 percent over last year in terms of funding for the payment safeguards alone.

Senator DURENBERGER. Now, Mr. Toby, you have been a Regional Director for HCFA. Can you describe for us how the prioritizing process works as between the appeals process, the safeguard process, all that sort of thing? Just reflecting on your own experience. Where are the safeguards and where is this in the usual priorities out there in the region?

Mr. TOBY. Well, I must tell you, Senator, coming from New York, I constantly argued for more money in the audit area. I was held responsible each year, and I got credit for doing a good job only when we got a good return on the investment. So, I used to always insist that we put more money into the audit area.

I felt that one thing that the Central Office always did here in Washington was to be very conscious about the payment safeguards area. Even in the 1980's, when funding was the most difficult, there was always interest in listening to the regional offices and talking to the contractors.

Senator Rockefeller mentioned autonomy; funding is one area where we sit down with the contractors and say, we only have a small amount of money, where do you think the priorities ought to be? It was generally in the payment safeguard area, and, also money to answer telephone inquiries from providers and beneficiaries. But, most importantly, we had to keep the claims processed so that we did not adversely affect the cash flow of our providers.

Senator DURENBERGER. One of the things that GAO found out in their study is laxity on the part of carriers in doing their investigations.

As I understand it, they looked at five carriers and found that over half the incoming phone calls that should have been referred for investigations were not. Even when investigations were started because of substantial indications of fraud and abuse—and I have got some examples here—almost three-fourths of the cases were not adequately investigated. Now, where does carrier discipline, if you will, come in, in the whole process?

Mr. TOBY. Because we recognized that the area of fraud and abuse needed increased attention, we are giving contractors separate funding and we have asked them to set up special fraud and abuse units with staff dedicated specifically to this area.

I think one of the difficulties in the past was that the contractors did not have a dedicated staff in this area. They also did not have separate funding in this area. We have now put resources there. Ms. Gagel has worried about this a great deal and she may have something to add to it.

Ms. GAGEL. More specifically, with regard to the GAO report itself, we and GAO, quite frankly, come to different conclusions when we look at that same activity of the carriers. We do not see the number of problems that GAO did.

Nonetheless, they did point out the need for us to tighten up our procedures, and we have done that. We have issued new instructions and new performance standards to our contractors with regard to investigating each allegation of fraud or abuse by a Medicare beneficiary and making a written record of that investigation. The contractors must provide feedback to the Medicare beneficiary within 14 days of the complaint and the action that they have taken with regard to the complaint. They have been doing that now for about 6 months, and it seems to be working quite well.

Senator DURENBERGER. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator. Senator Daschle, comments and/or questions?

Senator DASCHLE. Thank you, Mr. Chairman. Mr. Toby, I would like to pursue the contractor issue a little bit. You have indicated that it is the front line defense against fraud, and that you save about $6 billion in 1993, which comes out, as I understand it, to $15 for every dollar invested.

Blue Cross, I am told, will later testify that contractor funding is frankly inadequate. The Bush administration requested lower contractor funding for fiscal 1991. The fiscal 1992 request for contractor funding was about 2.5 percent below fiscal 1991 levels.

And the only reason that carriers could conduct the anti-fraud activities that they are conducting is because of the appropriated contingency funds that we have had to fight OMB to release, $70 million, as I understand it.

So, the question is, with all of that, if it is our front line of defense, why is it we are having so much difficulty in committing the necessary resources to ensure that they can do the job that they are intended to do?

Mr. TOBY. Well, Senator Daschle, one problem is the limited amount of funding available for Medicare contractor operations due to the Budget Enforcement Act.

This has, in turn, forced us to carefully balance contractor funding and we have done this by prioritizing. We have had to make choices. In a climate of limited resources, one has to choose. And I think, for the most part, we have not only worked hard and done the best we can, I think we have worked very smart.

Perhaps contractors have not gotten the amount of money they requested, but, for the most part, they have met the objectives we have set, which basically fall within a framework of priority setting.

Priorities were set to protect the claims processing function to make sure that the claims are processed within the mandated timeframes. It also means that we have been able to handle appeals from providers and from the beneficiaries.

And my sense is, that by working with the contractors, we have been able to do a fairly good job, and not only that, an exceptionally good job without a lot of money.

Senator DASCHLE. Let me just ask you. I do not mean to interrupt. But I question how good a job the system is doing, if the GAO is correct and that we are losing $70 billion to fraud. And I understand your point about the balancing of priorities; we all have to do that.

But what I hear you saying with that answer is that there is someplace in your overall effort where you can derive more in your investment than $15, which is what this is.

Given the commitment you make to contractors and the savings generated, that is a 15 to one ratio. What you are saying by that is that there are other areas where that ratio is even better. And I am troubled. I would love to have you tell me where those areas are and whether you are satisfied with that $70 billion estimate.

Mr. TOBY. That $70 billion estimate did not have to do with Medicare specifically. It was the health care system in general.

Senator DASCHLE. That is the system in general. That is correct.

Mr. TOBY. The estimate was for all of health care. Medicare and Medicaid combined represent about 25 percent of the entire system. The remaining health care system is covered by out-of-pocket, other government programs, and private insurance. So, we are not solely responsible for the $70 billion.

Senator DASCHLE. Well, let me rephrase it, then. Let us say it is only $18 billion.

Mr. TOBY. Yes.

Senator DASCHLE. Are we satisfied with an $18 billion fraud tag?

Mr. TOBY. No, sir. We are not happy about it at all. That is why we have four legislative proposals asking for greater flexibility so we can do a better job within the budget that we have submitted.

My sense is that even though funding has remained flat, we have been able to work in a very innovative way. We have done a great deal of automation. Automation has allowed us to get through this very difficult fiscal period and we have been able to protect the trust fund in a way in which we feel very proud.

Senator DASCHLE. Let me, in the time I have left, pursue another point that I notice you did not really address in your testimony.

The General Accounting Office makes quite a point of saying that one of the reasons why we have the level of fraud and abuse in the system is the complexity of the health insurance system overall, with 1,000 payers that process four billion claims annually. You have got Medicare itself processing 600 million claims. To what degree is the problem of fraud, in your view, structural?

That is, if we did everything right given the current system, gave you all the money you needed for enforcement through the mechanisms you have outlined, to what extent do you believe fraud would still exist, given the kind of complexity and extraordinarily burdensome organizational framework within which health care is delivered today?

Mr. TOBY. Senator, the HCFA budget is $170 billion. With that magnitude of money, the imagination of people is limitless. Consequently, they will find a weakness somewhere in the system. So, I suspect that there is no perfect system you could ever devise that the human mind will not be able to find a way to abuse.

So, my sense is it is a never-ending effort, and we have to always work hard, and work smart, and be as innovative as possible. And we need the flexibility at the Federal level to be able to take actions to correct it.

Senator DASCHLE. Well, I am out of time. I thank you, Mr. Toby. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Let me say two things. One, is that Chairman Bentsen, of the full committee, cannot be here today, Mr. Toby, but he has a number of written questions that he is going to submit to you. And he would, of course, hope for a prompt response.

Mr. TOBY. All right.

[The questions appear in the appendix.]

Senator ROCKEFELLER. Just following up a little bit on what Senator Daschle said—and this is just a single question. You made reference, and I forget whether it was a 17 percent or 23 percent increase over last year that you mentioned was being requested.

Mr. TOBY. Right.

Senator ROCKEFELLER. But both GAO and the Inspector General have said that the current levels are inadequate in terms of payment safeguard activities. And I just wonder how you would respond to that.

I mean, yes, there is going to be this increase. But is it going to be sufficient, or is it just what you have got to live with, and, therefore, you have got to make the best of it?

Mr. TOBY. We think this increase is sufficient, particularly if we get the full appropriation request, including the legislative proposals to reduce the cost of processing claims and, for example, to pay electronic claims faster. We think the electronic claims priority is one that will give us incredible efficiency and ability to monitor and to track claims.

We also want to be able to reassign fiscal intermediary functions, to cap cost reimbursement, and to eliminate contractor bonuses. We think that if we get these legislative changes, our budget request would be very sufficient, sir.

Senator ROCKEFELLER. All right. Mr. Toby and Mr. Gagel, thank you very much. I would just point out, not necessarily for those in this room but for those who might be watching that, in my judgement, the Health Care Financing Administration is probably, next to being Mayor of New York City, the toughest job in the western world.

Mr. TOBY. I will tell Secretary Sullivan what you said, Senator Rockefeller.

Senator ROCKEFELLER. Yes.

Mr. TOBY. Because he said the same thing to me 2 days ago.

Senator ROCKEFELLER. And I have a great respect for Gail Wilensky, and I make a practice of saying so publicly and I do so for the specific purpose that I want to say so, and also to say that in this matter of health care reform and waste, fraud, and abuse that essentially, even though it appears to the American public that we are constantly resolving ourselves into two political parties and that we do not seem to be looking at the people's interest, there is an interest on the part of a number of us who are serious about this, and I include, obviously, both of you as I did former Administrator Wilensky.

We want to do the right thing. We really do. I mean, there is just too much money involved here; there is too much at stake not to. So, I wish you well. I thank you both. I thank you for coming.

Mr. TOBY. Thank you, Senator.

Senator ROCKEFELLER. The third panel, and we have five today—you never can have a decent hearing unless you have at least four panels, Senator Daschle; that is the rule—consists of Michael Mangano, who is the Deputy Inspector General for Evaluations and Inspections for Department of Health and Human Services, and Janet Shikles, who is Director of Health, Financing, and Policy Issues in the General Accounting Office. We look forward to both of your testimony, and you will have to introduce your colleagues and compatriots.

Mr. Mangano, we might start with you, sir.

STATEMENT OF MICHAEL F. MANGANO, DEPUTY INSPECTOR GENERAL FOR EVALUATIONS AND INSPECTIONS, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. MANGANO. All right. Thank you very much, Mr. Chairman. We are very pleased to be here to testify on the problems of health care fraud and abuse in the Medicare program because this kind of activity really squanders very valuable program resources, as well as adversely affects the beneficiaries of our program.

The role of the Inspector General's Office is to protect the integrity of HHS programs, as well as to promote its efficiency and effectiveness through a program of investigations, audits, and evaluations.

The theme of my remarks here remind me very much like the opening line to *A Tale of Two Cities:* "It was the best of times; it was the worst of times." Let me explain.

It was the best of times, because I think the IG's office, over the years, has delivered on the promise it made to the Congress and the public to be a sound investment to protect the programs of our department.

With the discussion here today about returns on investment, I am very pleased to say that for every one dollar that you have invested in the Office of the Inspector General we have returned $72 back in terms of cost savings.

We have just completed the eleventh consecutive year in terms of increasing investigative accomplishments. Let me mention a few of them.

In fiscal year 1991 we had 2,343 criminal prosecutions and administrative sanctions; half of them in the health care area. Let me be more specific. Criminal prosecutions in the health care area by our office rose from 20 in 1982 to 163 in 1992. That is an increase of about 800 percent.

We have had over 1,000 administrative sanctions in the last year, that is, exclusions from the Medicare program. We have negotiated over 70 civil monetary penalties against health care providers, and obtained about $87 million in fines, restitutions, and judgments.

We are also very concerned about increasing the efficiency of the Medicare program and the solvency of the Medicare trust funds. And we would like to point out to you that each year we compile and deliver up to the Congress what we call our Red Book, which is our Cost Saver's Handbook.

All of the recommendations to save money in the programs in our department are included in that Red Book until they are enacted by the Congress or the administration.

That Red Book includes over 100 items; about 45 of them relate to the Medicare and Medicaid programs. If you took all of those recommendations, you would find a way to save about $26 billion annually.

Senator ROCKEFELLER. $26 billion?

Mr. MANGANO. $26 billion annually. That is correct. In my written testimony, I identify seven areas in the Medicare fraud and abuse area.

Senator ROCKEFELLER. Just to put that in context, that would cover every man, woman, and child in this country with health insurance coverage who does not now have it.

Mr. MANGANO. It probably would. That is correct. In my testimony, I focus on seven areas that we find particularly susceptible to fraud and abuse in the Medicare area and we have remained continually vigilant in each of those areas. I will just mention what they are very quickly.

First, we continue, as the earlier discussion identified, to investigate the $3 billion DME, durable medical equipment, industry for some of its questionable marketing procedures, use of loopholes and inflated charges. Over the last 3 years, we have succeeded in getting 80 convictions against fraudulent durable medical equipment suppliers.

We must compliment HCFA and the Congress for helping us bring about some of the reforms that have already been made in the industry, and still more need to be made.

Second, in the Medicare secondary payer area, is also ripe for your attention and continued vigilance. We have conducted over 30 audits and evaluations in the last several years in that area. We still believe that Medicare is paying about $900 million to $1 billion unnecessarily each year.

Third, the kick-back area remains a particularly burdensome problem, as physicians move to increase their ownership and compensation arrangements with organizations through which they refer business. Since 1987, we have had over 550 convictions, settlements, and exclusions in that area.

Fourth, in the last 2 years we have excluded 16 home health agencies' owners or employees because of either over-charging, charging for services that were not rendered, and other fraudulent abuse of practices.

Fifth, reimbursement manipulation continues to be a problem for us. This includes such unscrupulous practices as upcoding, unbundling, and recovery billing.

The sixth area is laboratory fraud, where laboratories are billing for tests that are not provided, billing for tests that were not necessary, and unauthorized tests. Once again, for the last 5 years we have had 50 convictions in this area.

Seventh, Medicare, we believe, is losing about $266 million each year because hospitals are retaining credit balances in the Medicare area.

I mentioned these are also the worst of times. And the worst of times I would define as health care outlays keep increasing at an

astronomical rate and we are uncovering more and more fraud and abuse each year.

Part of that is because we are detecting more fraud. We are getting better at doing that. Another reason is that we have pretty good cooperative relationships with other organizations, like Medicare, the contractors, the FBI, Postal Service, and other organizations.

The down side of that is that I do not believe that the OIG resources have been able to keep up with that increase. Just in the last year, Medicare and Medicaid alone will increase $34 billion, yet the OIG budget has not been able to keep up with that.

Our travel budget has been reduced 13 percent in the last year; investigative staff cut 12 percent. One way to look at it is we now have one Special Agent on the street investigating fraud and abuse for every $2 billion in health care outlays by our department.

Another way, is one for every 500,000 Medicare and Medicaid beneficiaries, or one for every 8,700 health care providers. We also need additional law enforcement authorities, like arrest, search, and seizure, to prevent the fleeing by felons and the destroying of records.

Let me say, in summary, that we believe that our role here is to look at individual incidences of fraud and abuse, but also to take a more broader perspective and look at some of the overall problems of the health care industry. Thank you very much.

[The prepared statement of Mr. Mangano appears in the appendix.]

Senator ROCKEFELLER. Thank you very much Mr. Mangano. Could one of you introduce your colleagues?

Ms. SHIKLES. Yes. I would like to introduce Tom Dowdal, who is on my far right, and Ed Stropko. They are my colleagues, who have been working with me on this effort to look at Medicare and payment safeguards.

Senator ROCKEFELLER. Gentlemen, welcome.

STATEMENT OF JANET L. SHIKLES, DIRECTOR OF HEALTH FINANCING AND POLICY ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC, ACCOMPANIED BY THOMAS DOWDAL AND EDWARD STROPKO

Ms. SHIKLES. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss the challenges that the Medicare program faces in assuring that payments to medical providers are timely and accurate while minimizing the loss of funds through fraud, waste, and abuse.

These challenges are hardly unique to Medicare. Similar challenges face all health insurers. We released a report 2 weeks ago in which we discussed the enormous cost the nation incurs as a result of health insurance fraud and abuse. Nobody knows for sure how much is lost, but many believe fraud and abuse account for some 10 percent of all health care spending.

In that report, we called for a national commission to develop remedies, in part, because of the inability of thousands of individual insurers to successfully address fraud and abuse independently.

In the current health care insurance environment, profiteers are able to stay ahead of those who pay claims for several reasons.

These include the independent operations of the various health insurers that limit collaborative efforts to confront fraudulent providers; growing financial ties between health care facilities and the practitioners who control referrals to those facilities; and costs associated with legal and administrative remedies to fraud and abuse.

Medicare is not only subject to many of these problems, but it also faces a challenge attributable to its complex administrative structure.

HCFA, which oversees the program, operates through numerous contractors responsible for the daily task of claims processing and administration.

This administrative network facilitates the handling of local needs and differences, but it can lead and has led to significant variations in administrative practices and payment policies among geographic areas.

Finding the appropriate level of national uniformity while leaving enough discretion to handle local differences and foster innovative approaches to address fraud, waste, and abuse is a significant difficulty facing HCFA.

Our work in recent years suggests that HCFA may need to exercise more aggressive oversight over its contractors and that, working together with the Congress, HCFA needs to assure adequate and stable funding for program safeguard activities.

As an example of some of our concerns, we recently reported on two areas where limited HCFA oversight of Medicare contractors contributed to a breakdown in program protections.

We found that contractors did not adequately investigate beneficiary complaints or recover hospital payments owed to Medicare, and that HCFA's contractor monitoring systems did not identify these performance problems.

The absence of a strong HCFA role has also contributed to contractors' weak controls over who can bill the program. This has made it more difficult to detect fraudulent providers who bill Medicare for millions of dollars in phony or unnecessary diagnostic tests.

Senator ROCKEFELLER. Ms. Shikles, we have your full testimony.

Ms. SHIKLES. Yes.

Senator ROCKEFELLER. We have it right before us. So, you can read it, but you may run out of time. You may want to pick out what you care most specifically about and kind of give it to us.

Ms. SHIKLES. All right. In fact, I was just going to finish that. We will soon report on how these limited controls over provider numbers were an integral part of a multi-million dollar scheme in Los Angeles involving mobile labs where these providers operated under about 30 different corporate names and Medicare numbers.

We have also identified problems in budget cuts and the lack of stability in payment safeguard activities which continues to cause problems to contractors that we have been working with.

In Los Angeles this year, they have seen a 25 percent cut in their payment safeguards staff, so that means if you get an increase this year, that will help, but, then, if you lose the money next year you lay the staff off again, and you never have any experience staff working in this area.

In conclusion, we believe that policy makers need to act to ensure that contractors have clear incentives to manage program dollars efficiently and effectively.

And one aspect of this issue is making sure that there is stable funding, and that is why we continue to support modifying the Budget Enforcement Act to ensure stable funding for payment safeguard activities.

However, in our view, and probably even more important, we believe that HCFA must also take a more active stance to hold contractors accountable for their performance in program administration.

This means, to monitor and direct contractor actions, they may need better information systems, more focused performance measures, and stronger contractor guidance. Thank you.

[The prepared statement of Ms. Shikles appears in the appendix.]

Senator ROCKEFELLER. Thank you. You know, my mind is kind of worrying around, Mr. Mangano. I think you held up that Red Book and said that herein are $26 billion worth of savings?

Mr. MANGANO. Yes. That refers to all of the programs of our department, not just the health care area.

Senator ROCKEFELLER. All right. All right. Well, that, then, reduces my trauma.

Mr. MANGANO. Yes. [Laughter.]

Senator ROCKEFELLER. It is really quite stunning here. I mean, Tom Daschle, Dave Durenberger and myself are accustomed to hearing, as I indicated, you put $1 into Head Start and you are going to save $4 in return.

And everybody is telling us here—I said I thought it was $1 to $14; the acting administrator said, no, it is $1 to $15. And then there have been higher ratios.

We are talking about enormous potential for saving. We have talked about $145 billion, and not everybody in this world is perfect and has opportunities to take advantage.

It is my understanding that both you, Mr. Mangano, who are within HHS, and Ms. Shikles, who are from without HHS, both highly respected, that you are saying, look, we need more money to do this.

Now, we had Mr. Toby before us saying that the President's 17 or 23 percent increase for fiscal 1993, or whatever it was, was sufficient. And I am trying to say to myself, here people out in the country think that we do not know how to run things in government.

I have always kind of made the case that Medicare is actually one of the more efficiently run things that government has ever done. There is very low overhead, and all of the rest of it. But we are talking here about enormous savings.

You both appear to be saying that we should be spending more money and figuring out how to cut out more waste, fraud, and abuse.

The acting administrator is saying, we really have enough, we can do enough. And then you are also holding up this book of $26 billion savings, generally, of what we do in HHS.

And I say, oh, well, that reduces my trauma. Actually, I ought to be in coronary intensive care at this moment. There is not enough money, I suppose, being put into waste, fraud, and abuse control.

Is that what you both want to tell me, that the acting administrator, in a sense, is pinned there because he is the acting administrator and he has to reflect the administration, OMB, and all of the rest of it? Let us just have this one out.

Mr. MANGANO. What I would say is that we have been doing a number of studies in the area of contractors. I think I mentioned we have done, over the years, about 30 different studies in the Medicare secondary payer area.

One of the outgrowths of those studies was a recommendation we made at least 1½–2 years ago that as we started to see the amount of money for safeguard efforts by the contractors starting to decrease—and they did decrease in fiscal year 1990—that we rang a cautionary bell and said that you ought not to do this. We testified before Congress about that, and we have made those recommendations formally to the department.

Senator ROCKEFELLER. Are you answering my question?

Mr. MANGANO. I hope so. My answer to your question is, yes, I think we need to have more money in this area.

Senator ROCKEFELLER. And how much more money?

Mr. MANGANO. I quite honestly do not know. But more money will be helpful.

Senator ROCKEFELLER. Give me a figure. It is your business. What do you think, Inspector General? What should there be?

Mr. MANGANO. I cannot give you a specific figure, but more is needed in this area. If we are having a return by the Medicare carriers of 15 to one, certainly more money in that area will give you a greater return.

Ms. SHIKLES. We also think that there needs to be more money in the area. What happened is that there was an increase in 1989, and then, ever since then, the money has dropped. It has not kept pace.

And we have been testifying in front of Congress, asking to put more money into the area. This is the first time that the administration has asked for more money in the area. The last few years, HCFA has asked for more money and then OMB cut it back. We think this is going in the right direction.

We would like to watch how much more money went into the area to make sure you got the payoffs that you are looking for. We are concerned that if you give the money this year and then it drops next year, you might as well not bother to do it this year.

Senator ROCKEFELLER. No. I think that point is absolutely on target and it needs to be emphasized.

I mean, that is what we do in the U.S. Trade Representatives Office. We get people trained and then along we come and cut them, or they are offered a job in the private sector—usually to lobby against the interests of our own country—and they accept it and they are gone, while other countries do not make those mistakes. And I think you are exactly right, there has to be consistency.

This is not an easy business. You have to learn how to do it, you have to be professional, you have got to have a sense of job secu-

rity, you have to have a sense that your department and your government is behind you. I mean, it has to do with morale as well as skills. So, I think your point is right on target.

Senator Durenberger, and I note that Senator Grassley who talked with me before this, has an intense interest in this area. So, maybe Senator Durenberger and Senate Daschle would forgive me if I went right to Senator Grassley, because you may either have a statement or some questions. Then I will go to Senator Durenberger and then Senator Daschle.

Senator GRASSLEY. And I will just put an opening statement in the record.

Senator ROCKEFELLER. All right.

Senator GRASSLEY. I will not give it. I will just ask questions now.

[The prepared statement of Senator Grassley appears in the appendix.]

Senator ROCKEFELLER. All right. Well, you got away on that one pretty good, Senator. Go ahead.

Senator GRASSLEY. I would hope you would appreciate that. This question is on the Medicare secondary payer program. You noted in your statement that as much as a billion dollars could be owed the program by primary insurers.

What do you base this figure on? Is there a good consensus between GAO, HCFA, and the Inspector General on the magnitude of inappropriate spending? And, of course, I ask because there are some who think that the amount that is owed the program is greatly exaggerated.

Mr. MANGANO. All right. We did a study about 2 years ago in which we tried to quantify the amount of money that was lost through the Medicare secondary payer. And in this study what we basically did was take a representative sample of Medicare beneficiaries and traced those individual beneficiaries back to find out whether there was primary insurance involved with them.

And rather than go through all of the steps that we went through in doing it, we found that there was a minimum of over $600 million lost in that particular year.

The data that we were using was about 4 years ago, so we then just increased that data for the amounts of increases in the Medicare program and came out to $900 million. In my opening statement I mentioned it was between $900 million and $1 billion being lost at the current time.

Ms. SHIKLES. And we have also been working in that area. Last year, after our working with HCFA, HFCA ran a survey with the contractors. They found $900 million to $1 billion in claims that the contractors have not worked to try to retrieve the money. And there is also an estimated $1 billion in additional claims that they have to work.

Senator GRASSLEY. Then the last figure refer to what would be owed now by the primary payer.

Ms. SHIKLES. That is correct.

Senator GRASSLEY. And that is a pretty solid figure, you feel?

Ms. SHIKLES. Well, nothing is real solid in this area. I think these are people's best estimates by going through the claims. And it looks like someone else should have paid the bill. You do not ever

totally know until you go out and make sure that there is not an error that you do not know about. It is a reasonable estimate.

Senator GRASSLEY. Then let me get to that point about the difficulties that we have in mechanically making it work. Have you reviewed the way in which the Medicare program identifies primary payers and do you have a comment on how credible it is, how exact it is, I guess, just the mechanics of it?

Mr. MANGANO. One of the areas that we think is the biggest problem areas is in the Part B area. Under Medicare Part A when people are admitted to hospitals, the hospitals do a very credible job in collecting the primary payer information. The area that we have found has been the most difficult is in Part B.

That is why we have made recommendations over the year that Medicare ought not to pay the claims until that part of the claim form is completed that says, do you have another payer of insurance. And if Medicare could do a better job in that area, it could reclaim more money.

The area that is most prone for Medicare to pay as the primary as opposed to the secondary payer is when the spouse has insurance through their primary employer.

Because of that, we have recommended to HCFA that they really focus on that part of the secondary payer that is not being collected right now, because that is the area that they are going to have the best opportunity to lay claim to.

One of the other problems is that Medicare, at the current time, is unable to run claims against private insurers.

One of the other recommendations we have made is that they ought to be able to match them, particularly when you consider that the contractors are all insurance companies themselves, and they have contracted with the government to pay the Medicare claims.

But, yet, are unwilling, at least at this time, to match their own private health insurance data against the Medicare data to detect whether they are primary or secondary payer.

Senator GRASSLEY. What about for other insurance companies where they do not have records?

Mr. MANGANO. Well, that is a real big problem.

Senator GRASSLEY. I mean, that is a complaint we hear.

Mr. MANGANO. Yes. That the insurance companies do not have the records? I am sorry. I am not sure I understand your question, Senator.

Senator GRASSLEY. Yes. If there is another insurance company involved.

Mr. MANGANO. Yes. That is correct. The difficulty there is that Medicare needs to be able to identify that other insurance company. The easiest way to do it is on the preventive side, and that is to collect that information up front when the person presents themself to their physician or to their medical lab for a blood test.

If we can identify it up front, then we do not have to go through this search afterwards. It is very labor-intensive and very costly. So, mechanisms that can identify them up front are best.

Senator Grassley. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you very much. Let me just ask you both of you questions about reforms. I am going to be reading some of the recommendations from the Inspector General's report, one of which is a national single pricing schedule with local market variations.

Just quickly, does local market variations mean the price of sales establishment, rent issues, things like that? Is the notion that the basic product would be the same across the country?

Mr. MANGANO. That is correct. I think you are referring to a recommendation we made in the durable medical equipment area.

Senator DURENBERGER. Yes.

Mr. MANGANO. But if I could broaden that question a little bit, as we look at contractor operations over the years, back when Medicare was established by the Congress in 1965, we set up a system in which we had over 80 contractors that would pay the bills for Medicare.

And one of the reasons for the fact that we had so many of them were that the way that we paid our bills was according to the usual, customary, and reasonable charges of local physicians, local labs, et cetera.

We wanted to take into account that it would cost more in New York for a certain product than it might in a rural town somewhere else in the country.

Senator DURENBERGER. You mean, it costs more to sell it. The product itself does not cost any more, does it?

Mr. MANGANO. Buy it, sell it, produce it. That is correct. But, over the years, what has happened is that as we have moved closer to a national standard for things, like prospective payment. DME has established a national standard for reimbursement of durable medical equipment that takes effect January of next year within 15 percent of one another.

Do we really need to have as many contractors making independent judgments as to what they are going to be reimbursing and how much they are going to reimburse it? We think that we ought to be looking at that.

We are pleased that HCFA has taken one of our recommendations in the DME area, and that is they are going to reduce the number of carriers that they have down to four. And that is a step in the right direction.

Senator DURENBERGER. I appreciate that.

It leads into the next question. You know, you cannot read this without getting very angry, because it leads you into improving the definitions for DME, and then you get into medical effectiveness, and then, more importantly, medical necessity.

Mr. MANGANO. That is right.

Senator DURENBERGER. And that gets to be the key. What angers you as you go through all of this—you work your way into kickbacks, into the drugs, into the wonderful home blood glucose monitors and so forth—is the involvement of the physician.

I am not just talking about the obvious con stuff. It is the fact that the physicians are not taking either financial or other responsibility for their decisions, as long as somebody else is paying for all of these things.

It is easy to say, well, try one of this, two of this, or something else. Perhaps from both of your reviews, you can talk to me a little bit more about how in the world we hold physicians responsible for all of these decisions.

My instinct is to say we will give you X number of dollars for each of these diagnoses, and you decide how much and what kind of DME, or drug, or whatever. But maybe both of you have some suggestions for us in that regard.

Mr. MANGANO. That really gets at a problem that we have been looking at over the years. Just about 2 years ago we did a report directly to the Congress that you had asked us to do.

Taking a look at physicians' financial arrangements with organizations to which they have an ownership or compensation agreement. We only looked at clinical labs, physiological labs, and durable medical equipment suppliers at the time.

And what became very clear to us was that if a Medicare patient was going to a physician, that physician was ordering up 45 percent more clinical laboratory services than a physician that had no ownership or compensation arrangement with a lab.

I do not question the fact that physicians in this country are honorable people and do the best for their patients. The only difference that we could find between the two groups of physicians—those who had an ownership arrangement and those who did not—was that those who were able to financially benefit themselves were ordering up more services.

In the clinical laboratory area we were able to conservatively estimate that increase to be $28 billion a year. And I know that Congress acted on that recommendation and precluded it for clinical labs. So, we have a very serious problem here where a physician is responsible.

Senator DURENBERGER. The problem I am having is with the solution. If you start from San Francisco or something like that, you are thinking in terms of big city and all that.

If you think of us here, we are representing people that want to combine. We are talking about people who would like to have the doctors, the hospitals, and a lot of these people get together to have a community system. But, gosh, if they try to do that in any one of our rural areas, bang, they run right up against your recommended solution.

Ms. SHIKLES. But we think there are things that you can do that sort of up front might put some controls in place that do not burden the honest providers or the kinds of situations you are talking about, particularly in rural areas.

Things like one single, even national provider number, but certainly one billing number, not the 30 numbers; identification which HCFA now has the ability of putting right on the form if you have an ownership investment in some facility that you are referring a patient to; and, some requirement by HCFA that you cannot just put some equipment in the back of your van and then start billing Medicare. What is it that you would like to require from someone who is billing Medicare?

And if you do just a few simple things like that up front, this does not burden the honest provider in any way. But I think you

begin to cut down on some of the abuses that we keep seeing in DME, and in other areas.

Senator ROCKEFELLER. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. Ms. Shikles, I am impressed by, first, the study, and, second, by many of the points you make in your statement. In the first page of your prepared statement you cite the fact that our multi-payer system, in part, is responsible for a lot of the problem that we are experiencing.

You say that over 1,000 payers which process four billion claims to hundreds of thousands of providers; the fact that independent operators that have collaborative efforts to confront fraudulent providers, growing financial ties between health care facilities and the practitioners, a whole range of character flaws, perhaps, in the current system is responsible for part of the difficulty.

To what degree, from your studies, have you been able to compare our system with European systems or the Canadian system with regard to fraud? Do you know the degree of fraud which exists here versus what it might be elsewhere?

Ms. SHIKLES. No. We have done studies of other countries' health care systems, but we have not looked at the degree of fraud or abuse, or how they detect it.

Senator DASCHLE. Looking at our own system, we have more than one health care delivery system in this country. Of course, we have the Veteran's Administration, the military health delivery system, and then, of course, our private health delivery system.

Have you ever had the opportunity to examine the degree of fraud which exists in those systems versus the degree of fraud which you know now to exist in the private system?

Ms. SHIKLES. Well, I have looked at Medicare and I have looked at a lot of private insurers in the work that I have been involved in. And it is pretty extensive. Every time you put a check in place, every time you go to look for something you find problems.

Ironically, Medicare is ahead of the private insurers in terms of detecting and catching problems. The private insurers that we have met with would kill to have some of the things that Medicare could do.

Senator DASCHLE. That was going to be my next question. I am not sure I got an answer to the question about the comparative advantages or disadvantages in the private system versus the Veteran's system or the military system. But your answer relating to Medicare was going to be a question that I also had.

In this study, you obviously look at Medicare and the private health insurance system. To what degree are the advantages very clearly evident in Medicare over that in the private sector?

Ms. SHIKLES. Well, the advantages in Medicare are that it is more standardized and you theoretically are running only one system as opposed to, in the private sector, you have thousands of different forms and many different payers.

People come in and they have different co-pays and deductibles. And none of these private insurers talk to each other; they do not talk to Medicare, either.

So, if one detects a problem, they do not tell anyone else, there is no sharing of information. It is very easy to scam our system right now if you want to do that. Things are a little better in Medi-

care because it is standardized, the program benefits are more similar, the beneficiary forms are more standardized. Even though we run it through 80 different contractors, compared to the private sector, it is a very standardized system.

Senator DASCHLE. Do you have any figures that would give you some calculation as to the efficiency of Medicare and that of the private health care system? Out of that $70 billion, Mr. Toby had indicated that a fraction of that was related to Medicare.

But that does not really tell us the story in terms of relative efficiency because, obviously, there are a lot more people using the private system than there is using Medicare.

But to what degree, is there a way to determine the degree of efficiency of Medicare versus the degree of efficiency or lack of efficiency of the private system?

Ms. SHIKLES. We did not specifically look at that. I would guess that Medicare is much more efficient than private insurers.

Senator DASCHLE. But there is no way of calculating that. Is that what you are saying?

Ms. SHIKLES. I would like to think about it. I do not know.

Mr. DOWDAL. I think it depends on what area you are talking about. If you are talking about overall administrative costs, there are numbers you can get on that and Medicare is substantially below the private sector firms.

If you are talking about what percent of Medicare claims are represented by fraud and abuse versus those in the private sector, there is no information available that would let us get an estimate of that.

Senator DASCHLE. It would seem to me that comparative analysis using computer data and everything else that you have available to you would allow you to analyze with a lot more precision the savings generated from a Medicare-like system over that of a multi-payer-like system that we have in the private sector.

And that, on a per capita basis or some kind of a unitized comparative analysis you would be able to come to some conclusions with regard to the efficiency of Medicare over that of the private sector. But what you are saying is that your current study does not do that.

Is there any way, over a period of time, you might be able to share something like that in greater detail with the subcommittee?

Ms. SHIKLES. Well, we would be very happy to look at that issue and get back to you and see what we data is available.

Senator DASCHLE. I would appreciate that very much. Thank you.

Thank you very much, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Daschle. People from South Dakota are very well-mannered, very civil. I want to sort of pursue what I think Tom is restricting himself from saying in a more direct manner. I mean, this is sort of the problem.

Tom is for single payer, government does it all. So far, if I were to be an American citizen sitting out there listening to the people who have testified, I would say Tom wins. I am for play-or-pay. That means that about two-thirds of the private insurance market is eliminated because they should not be in the business in the first place because they cannot afford to do business and manage risks.

They are just doing adverse selection. I do not know what Senator Grassley is for.

Senator GRASSLEY. Consumer choice.

Senator ROCKEFELLER. Consumer choice. So, that means that is sort of tax credits, vouchers, deductibles, that kind of thing. In other words, it is the individual up against the insurance company.

But everything that you are saying here, you are saying a major impediment, talking about all 1,000 payers, four billion claims annually, hundreds of thousands of providers.

Then you get down to disadvantages. HCFA's ability to manage—Janet, this is you—a consistent national program is limited by the variations in contractor's interpretations of Medicare rules and regulations.

Up above you said, "As a result contractors were given considerable discretion in setting and implementing payment and safeguard policies. Much of this latitude is retained to this day."

And I keep thinking of that Red Book, with $26 billion for all of HHS. I mean, are we not being fairly generous about this? I mean, Blue Cross/Blue Shield does a lot of this.

Of course, they are all fragmented; in name only are they one company, so to speak. But should we not be reducing this to very, very few people, and you should be sitting there telling me exactly they ought to be doing because this is taxpayers' money and we are talking about billions of dollars?

The least amount of money that I have heard talked about that we are wasting is $6 billion, and that was by Mr. Toby. I mean, now why are we putting up with 84, then 34 or four?

I mean, should this not be much highly rationalized? Is this free enterprise that we are trying to save here? Are we trying to bail out the insurance industry? What is going on?

Mr. MANGANO. One of the things that I would say in response to that is getting back to a notion that we have continually pushed in a variety of the studies, is getting down to more uniform ways in which Medicare will set its reimbursement rates, more uniform ways in going after exorbitant costs.

One example that ties a little bit of what you have asked and what Senator Daschle has asked, and that is, one of the things that disturbs us a bit about the way that Medicare pays for its products is that they do not do enough competitive bidding. In the private sector, HMOs, I know, go out and competitive bid almost everything. Medicare needs to do that.

Senator ROCKEFELLER. Why do you not? You are Inspector General.

Mr. MANGANO. We have made recommendations in those areas. We have convinced them to do it in the cataract lens area where Medicare was paying $350 for the interocular lenses that are implanted in cataract surgery.

Our study of the Canadians, HMOs, and the Veteran's Administration show that you could buy it easily for under $200. We convinced HCFA to make that change. That change alone can——

Senator DASCHLE. Could I just interrupt up there, Mr. Chairman? But why is that the case in all these other instances that they can buy it so much more cheaply?

Mr. MANGANO. Under the Medicare process, the Medicare program was reimbursing the hospitals and ophthalmologists who were performing the surgery for their reasonable and necessary costs.

Those costs were not taking into account the fact, though, that if they had gone out and bid for those they could have gotten a much lower price.

And, second of all, the lens manufacturers are rebating a great deal to the individual physician, whereas, in all of the other examples, they were competitive bidding and they were driving the price down for exactly the same lenses.

Senator DASCHLE. But were they not bidding competitively because there was a single payer?

Mr. MANGANO. No. Well, in the Canadian system you had the individual Provinces and hospitals——

Senator DASCHLE. I think in every instance you mentioned there was a single payer, whether it was the Veteran's Administration, the military, any one of the foreign systems.

You have got a single payer, a determinant, somebody who is making a decision with regard to how much they are willing to pay for a given service or a given piece of equipment. That is the fundamental difference.

Mr. MANGANO. That is correct. But I also think those kinds of scenarios can play out in Medicare as well as Medicaid. States and Medicaid can do that, too.

Senator DASCHLE. I agree. I am not arguing that point.

Senator ROCKEFELLER. You would be agreeing on that point.

Mr. MANGANO. That is correct.

Ms. SHIKLES. Our concern about Medicare is that we feel that they are overloaded and in a reactive mode.

For example, last year we got a tip that there were credit balances or money owed Medicare sitting at a hospital. We went out to the hospital in Maryland, and about $300,000 was sitting there owed to Medicare going back a couple of years. And we went to the intermediary.

And then we just went to 16 other hospitals, and we found money sitting at every hospital. This is the whole credit balance issue. And there were five intermediaries involved.

The intermediaries either did not know about the problem, or they said they did not have the time or the money to solve it. They were not aggressively doing anything about it. And this is a lot of money.

So, we talked to HCFA last spring. They immediately put in a monitoring system to alert all of the intermediaries. They started to get the money reported, and then OMB put a stop to the form, which you mentioned earlier.

Senator ROCKEFELLER. Giving what as a reason?

Ms. SHIKLES. That they had not gotten clearance from OMB, so they stopped HCFA from having hospitals report in on how much money was owed back to Medicare.

But the point is, in the jobs we and the Inspector General have been doing, we find problems, beneficiary complaints, fraud situations not being investigated, and HCFA then responds and they do a good job of putting something in place. But we do not think this

makes sense. I mean, years go by, it takes a long time to get the regulations out. A lot of money just flows out there.

And we would like to see HCFA now take a very pro-active stance, and that is why we are really glad you are having this hearing today. Because we would like them to come up with an aggressive strategy of putting some controls up front, in place.

HCFA is trying to move in that direction, but we do not think they are there yet.

Senator ROCKEFELLER. Yes. I understand that. My light is not on, and Senator Grassley or Senator Daschle can continue questioning you if they want.

But, I mean, my point is this, that I have been here, what, 7 years, Tom? And is this not the first oversight hearing we have had on Medicare? And I am not going to go into the reasons why that is the case. All I know is that I am pretty angry about it.

And basically I am being told, I guess Mr. Toby mentioned earlier $6 billion worth of saving, and then gradually as we push you you are showing more and more frustration, and the courtesies of this exchange become a little bit more open.

And what I am looking at is if we can get another $3 billion out of this that would be saved every year, that means that automatically we can vote for health care reform which would cover 500,000 pregnant women in this country that do not have any health insurance and are not going to get any prenatal care, and every child through the age of 18 on $9 billion, which is exactly what it would cost.

And if I am an American citizen looking at this, and we have that $26 billion in HHS, which is kind of neatly laid aside, and then I get stronger and stronger reactions out of you the more Tom, and I, and Chuck press.

And you finally end up by saying, well, we really think that HCFA should be doing more up front. I mean, I am developing a fairly hot attitude about all of this.

Plus, the question of let us do this, bid things out to everybody, and you said they do not talk to each other, much less HCFA. I mean, what is going on here? We are talking about billions and billions of dollars.

I do not ordinarily get exercised in hearings. I am a perfectly decent person, well brought up, love my mother and father. But this is a very, very unsettling turn of events. I am not trying to blame anybody, but I am blaming all of us, I guess. I will just stop for the moment. Senator Grassley, you and Senator Daschle both have rights to more questions if you want to. If I were Senator Daschle, I would be feeling pretty good right now.

Senator GRASSLEY. I had a couple of other things that Senator Daschle dealt with, but since we are having a vote I had better go immediately to a couple of follow-ups from what we were talking about previously.

One is about how we identify the primary payer. And the reason I ask, is it seems to me that that is a key part of this program. I gather that you believe that the information should come from the beneficiary via the provider. Can we make that work without a revolt by providers if we refuse to pay a claim until we have that information?

Mr. MANGANO. Well, that is a requirement of the program that just has not been implemented strongly enough by HCFA. The providers are to get that information when the patient comes into their office.

As we can all recall, when you go to your physician, they have you fill out forms. One of the pieces of information is, do you have another provider of health care.

Senator ROCKEFELLER. Can I interrupt? Senator Grassley, would you Chair while I go down and vote? And I will be back. We have got 14 minutes. I will come back, and then we can go to the next panel. Or if you want to bring on the next panel, that is fine.

Senator GRASSLEY. Yes. Make sure they wait for my vote.

Senator ROCKEFELLER. I will be sure of it. [Laughter.]

Mr. MANGANO. So, that really is the most cost efficient way to do it, is to get that information up front. Most people are honest. We do not find that the beneficiary is hiding the information.

It is just that they may not have been asked, they did not fill out that part of the form. Because when we went out and did our study, we asked the beneficiaries. And that is how we came up with the figures that we did.

Senator GRASSLEY. Well, could you also address the data match program? Is that a good way to get the information, given that the whole project can be very burdensome to employers who have to fill it out?

Mr. MANGANO. I think the data match, as it is currently structured where we are matching Social Security against IRS and Medicare records, the jury is still out on how well that is going to work. It is a very difficult process.

Mr. Toby had mentioned that they expected to collect $600 million additionally this year. Once this program gets a little bit further along, we are going to do a review of it and see how efficient it really is.

What we have advised HCFA to concentrate on is those matches which identify spousal insurance, because that is the area where you have the best probability of being able to find a primary payer.

Senator GRASSLEY. How would you update that information once you get it?

Mr. MANGANO. They are intending to do that once a year by using the Social Security income information. So, each year they will be going back to Social Security for that match.

Senator GRASSLEY. I have a question that is a little bit different, but it deals with the inappropriate payments by private payers. And this is information from a flyer that is distributed by the Society of Professional Benefits Administrators, and, according to this, an employer may be required to pay twice for a claim. This can occur, according to them, when a provider bills both Medicare and an employer plan.

Both Medicare and the employer plan may have paid the claim, but the Medicare contractor may seek to recover from the employer plan without realizing that the employer plan has already paid. Then they go back to the individual. That is a problem, you see. Do you have any idea how often this happens?

Mr. MANGANO. It is a problem that happens, and that is one of the reasons why we have the problems with secondary payer. It is

also one of the causes of what Janet was talking about in terms of credit balances.

A number of times a hospital, not knowing whether they are going to get paid or not, will submit the claim to the individual's private insurance company, and, at the same time, submit it to Medicare.

Now, let us suppose that the private insurer paid and Medicare pays. It is up to the hospital, then, to go back and report that, that they have gotten payment, and return that money to the Medicare intermediary.

We have found in our studies—and I know GAO has found in theirs—that a number of times that the hospital does not go back to the intermediary and tell them they have it. Even more burdensome is that sometimes the intermediaries do not go out to collect it, even after they know it exists.

Senator GRASSLEY. Picking up again on the question of efficiency of Medicare, and this would follow on what Senator Daschle was saying and not taking exception to anything he says.

But I just want some sort of commentary from you, as efficient as Medicare might be—presumably more efficient in administering than other programs—that does not, though, does it, take into consideration what I call the hassle factor, the paper work requirement that is put on the providers and not accounted for, I think, in your statement? Janet, what do you say?

Ms. SHIKLES. Well, our work, and we talked a lot and met a lot with private insurers, as well as public payers, and they have concerns about, as you said, the hassle factor, the administrative burden, and detecting fraud and abuse.

And that is why they would really like some joint strategies. And we think these strategies can be put in place, whether it is a single payer or our current approach, and get a reduction in administrative hassle as well as a reduction in fraud and abuse.

And these are strategies such as standardized claims administration, which Secretary Sullivan is leading an effort to achieve; a single provider national number so that all insurers cannot be gamed by these multiple provider numbers, and more sharing of information among insurers.

Senator GRASSLEY. So, what you are saying is it not only makes Medicare more efficient at the level of the government administering it, it also is going to make it more efficient for the providers so that that cost should be less.

Ms. SHIKLES. Yes, it should. That is right. And the private insurers, as well.

Senator GRASSLEY. One last comment. I just wondered if you had had a chance to look at the legislation that I introduced, I think it was in March, The Medicare Funds Recovery Act of 1992, that sets up a separate line item in the budget so that we would be able to have more money.

We recover, on average of $11 or $12 for every $1 spent in this area; to spend more to get more back so that we cut down on the cost of Medicare. Do you have a position on it yet?

Ms. SHIKLES. Well, Ed has been working in this area particularly.

Mr. Stropko. Yes. We support the general concept of the three bills that are out there. All three reduce some of the difficulty in increasing appropriations for safeguard activities.

Senator GRASSLEY. So, then, supporting the concept means that a little bit of fine tuning needs to be done with my bill, but you would be working in that direction as one of the three bills?

Mr. Stropko. Exactly.

Ms. SHIKLES. Yes. That was our original recommendation before Congress last year to follow a different approach to funding payment safeguard activities; funding for those activities that return money to the Treasury.

Senator GRASSLEY. Let me check with Senator Rockefeller's staff. I believe it is all right if I dismiss this group.

And then I will ask the next panel to come up. But I will not start the next panel. That would be a panel consisting of Sharon Allen and George E. Spalding. Just come up, and then I will recess the meeting and I will go vote.

[Whereupon, the hearing was recessed at 4:31 p.m.]

AFTER RECESS

Senator ROCKEFELLER. We welcome you, Ms. Allen and Dr. Spalding. Allen, why do you not proceed?

STATEMENT OF SHARON ALLEN, EXECUTIVE VICE PRESIDENT, GOVERNMENT SERVICES PROGRAMS, ARKANSAS BLUE CROSS AND BLUE SHIELD, LITTLE ROCK, AR

Ms. ALLEN. Thank you, Mr. Chairman. I sincerely appreciate this opportunity today to share our views with you on our role as the Medicare intermediary and carrier and our activities to protect Medicare from inappropriate payments.

Arkansas Blue Cross and Blue Shield has been a part of the Medicare program since its inception. And, in the State of Louisiana, we have been Medicare's Part B claims processor since 1984.

For 29 other Medicare contractors, by the way, including several commercial insurance companies, we also provide claims payment system support and are considered by some, at least, as leaders in the development of innovative and efficient claims payment systems.

Last year, we processed nearly 13.5 million claims for some 900,000 Medicare beneficiaries and their health care providers. We also saved Medicare a total of some $98 million through our payment safeguard operations and another $500,000 through fraud and abuse detection.

These are impressive results, perhaps, and they are certainly ones that we are proud of. And while we do a good job, we are deeply concerned about the direction of the program. We are concerned because so much more can and should be done.

But, increasingly, we are seeing the administration of Medicare becoming a bills payment operation, meaning that the number one priority is to get claims paid and get them paid on time, while in our private business we are being pushed by employers to look at the total cost, not just claims processing efficiencies.

We are being relied on to conserve health costs, to prevent waste, and to stop unnecessary and inappropriate payments. And that is exactly what we think we should be doing with Medicare.

The solution starts, we believe, though, with timely and adequate funding for managing the payment of Medicare benefits. Let me give you just a few examples of what I mean. Let us start, if you will, with medical review.

In Arkansas in 1992, we expect to process 1.7 million more claims than last year, which, for our operation, is roughly a 13 percent increase. But, because of funding constraints, roughly 135,000 fewer claims will undergo medical review than underwent review last year.

On the audit side, which has been mentioned today, that being our final check of the accuracy and validity of bills submitted by hospitals and other health care facilities, believe it or not, in 1992 we are essentially not reviewing any hospital cost reports to validate their claims for payment.

Rather, our audit effort is being directed into establishing the payment baseline for the capital cost of hospitals so that they can begin to fold that in to the DRG payments.

What I just said is somewhat of a misnomer. We have actually been funded to do four audits next year, when we should be doing a minimum of 50. That concerns me, because last year we saved the program $15 million based on those 50 audits.

Medicare's secondary payer. I think GAO has already told you that there is a growing backlog in MSP cases; those cases that are estimated to save Medicare between $1–2 billion if the staffing were available to collect all of those amounts from the other payers. We find that to be pretty much the case at home, too.

And, finally, fraud and abuse. You know, all of the activities I have just mentioned are really what help to detect and prevent fraud and abuse. And, by Medicare's efforts to stop fraud, there certainly is a ripple effect of reducing unnecessary health costs throughout the economy—cost shifting.

The administration has proposed in its 1993 budget a separate $24 million fund for these efforts. It is the first time specific funds have been identified for this purpose, and I can tell you we wholeheartedly support that increased emphasis.

In summary, let me simply say that we think the GAO has the right idea. The place to start on the problems is to make sure that Medicare administrative funding goes hand in hand with claims volume.

That is why we are also supporting the legislation introduced in the Senate by Senator Harkin and Senator Grassley. In the House there is a similar bill that has been introduced by Congressman Rostenkowski.

We want to work with you to improve Medicare. We have a talented and dedicated group of employees that are ready and eager to do the job. I think they need to hear that the discussions here today are going to truly be translated into some positive actions.

I thank you very much, and will look forward to any of your questions, Senator.

Senator ROCKEFELLER. Thank you, Ms. Allen.

[The prepared statement of Ms. Allen appears in the appendix.]

Senator ROCKEFELLER. Dr. Spalding.

STATEMENT OF GEORGE E. SPALDING, M.D., MEDICAL DIRECTOR, MEDICARE ADMINISTRATION, TRANSAMERICA OCCIDENTAL LIFE, LOS ANGELES, CA

Dr. SPALDING. Thank you, Senator. I am Dr. George Spalding, the Medical Director for Transamerica Occidental in Los Angeles, the Part B carrier for the Southern California area.

I have been so employed for a little over 2 years. I am a Board Certified surgeon that specialized in cardiovascular surgery. And I am going to discuss somewhat about the carrier medical director's role in this process.

In 1988, there was a discussion between the American Medical Association and the administrator of HCFA, the result of which mandated that every Part B carrier employ a full-time medical director.

Since that time, the duties of the medical director have gradually evolved and are continuing to increase in a beneficial manner, I believe. The medical director serves to provide a source of medical information to the carriers and to HCFA.

We interface with medical societies and providers; we assess current health care trends and technologies; and we also develop and assist in the developing of local and national policy issues under HCFA direction.

And this is one of our main functions now, and we meet nationally to develop issues that are widely acceptable across all carriers. And we found that when such can be developed they are much more effective and much more efficient.

The medical director takes a leading role in determining when medical guidelines need to be developed, or when they need to be revised, and to defend those guidelines when challenged. He also assists the carrier in his contacts with the medical community.

But, when I interface with the medical community and with physicians, talk invariably turns to the so-called "hassle factor." This perceived difficulty is a result of the complexity of the Medicare program and its guidelines and regulations.

In reaction to provider complaints, HCFA has directed us to move toward focused medical review. This is where emphasis is directed to those providers whose services clearly vary from those of their peers.

By statistical analysis of billed services, carriers can compare national practice patterns of specialty groups, geographic areas, or even particular physicians or suppliers.

This process allows us to identify potential fraud, abuse, or unnecessary services. It also helps carriers choose the most effective response, whether to develop better guidelines, to provide educational assistance, or to pinpoint enforcement efforts.

A targeted review, which I have just been discussing, is a more effective use of carrier resources than random audits and may relieve the medical community from broad-based restrictions or perceived hassles. We have found that to be definitely the case.

Peer review organizations which are in place perform some medical review functions for both Part A and Part B. However, it is ap-

parent to us that this represents a duplication of efforts already undertaken by the carriers who process the claims for Part B.

As a medical director, I am directly involved with our Program Integrity Unit in monitoring of fraud and abuse. This is an interdepartmental effort, relying on pre-payment Medical Review staff, post-payment Program Integrity staff, and the expertise of consultants in every major field of medicine.

In order to accomplish our goals, we must continue to refine our medical review function. We believe this can best be accomplished by a joint effort of pre-payment and post-payment review. To perform one without the other is like clapping with only one hand.

Carrier medical review is an efficient means of generating a savings to the Medicare program. At Transamerica, for every administrative dollar spent, we save $12 benefit dollars. And that is our statistic. Continued funding of medical review is crucial to the program's success. Thank you.

[The prepared statement of Dr. Spalding appears in the appendix.]

Senator ROCKEFELLER. The business of duplication with the PROs is serious. All carriers all have medical directors. Am I right?

Dr. SPALDING. All of the carriers do. Yes.

Senator ROCKEFELLER. Yes. And you are focusing, among other things, on the appropriateness of what?

Dr. SPALDING. The appropriateness of the service that is billed.

Senator ROCKEFELLER. All right. Now, you do see increasing overlap?

Dr. SPALDING. Yes.

Senator ROCKEFELLER. They have their duties. PROs have their duties.

Dr. SPALDING. Yes.

Senator ROCKEFELLER. You see the overlap, and what is your next response? What would you do about it?

Dr. SPALDING. Well, I think that they are providing some of the services that we provide. And I think that possibly there should be some mechanism of eliminating the duplicative effort.

Senator ROCKEFELLER. And who would get un-duplicated?

Dr. SPALDING. Well, as it is now, I think that the PROs should be directed to their main effort, which is primarily Part A, primarily determining the appropriate length of stay in hospitals and the appropriateness of admissions, the length of stay, and the care that was given.

But we, as payers for the Part B claims, have to decide whether or not the services were necessary or whether they were given appropriately in an efficient manner.

And we have the complete data base of all of the claims payment history so we can tell whether or not the patient really needed the service. I think it is important that the carrier probably has access to more data on the patients and the beneficiaries than the Part A people, the PROs.

Senator ROCKEFELLER. You also mentioned the hassle factor. Obviously, everywhere I go, physicians are consumed by the hassle factor. I think that comes from two reasons. One, is that they are being hassled, and the other is that they are not accustomed to being hassled very much at all.

And, like most people in America they have had a fairly free hand. They have been in a situation to control their practice the way the world works.

Now, because they are receiving enormous amounts of public money which they may or may not regard as relevant to how they should be treated, they are getting hassled, and it is real. What are some of the specific examples of hassle that strike you as unnecessary for doctors to go through?

Dr. SPALDING. Well, they complain about too much paper work and too much control over how they can practice. Although, I think a lot of this is very necessary, myself, to make the program function efficiently. I do not think we can give them a free hand, really. I do not.

I think that, however, a lot of the hassle factor that they perceive can be diluted by the methods that I discussed in directing our attention only to those people who are truly offenders.

We know that the majority of the physicians in the United States are good doctors and are not gamers. And if we can find ways to direct our efforts to the people who are outliers, I think we will be defusing the hassle factor.

Senator ROCKEFELLER. All right. Ms. Allen, where do you perceive to be the deficiencies? You were very good, and thorough, and precise in defense of the resources that you have and the attitude of your employees, and everybody is ready to do their work. Earlier, I had made a comment that if billions of dollars were at stake—and they clearly are—that maybe there ought to be—

And the statement was made and you can comment on that, too, that a lot of those who were looking at all of this, of the insurance carriers, they are not communicating with each other or they having a hard time understanding the rules, or that there is a lot of misunderstanding going on.

I will just make the proposition that there are too many people doing this. There are too many of you all doing this. There ought to be fewer, and it would be more efficient if there were. And either argue that, or whatever you choose to do with that statement.

Ms. ALLEN. With reference to the total health care industry, or just Medicare?

Senator ROCKEFELLER. I am referring to just Medicare.

Ms. ALLEN. I think, Senator, that the biggest problem that I have, perhaps, with reducing, if you will, number of contractors, is the local service aspect, the knowledge of the local people in dealing with the beneficiary. I sometimes think we forget the patient in all of this. They sometimes have a hassle factor, also. I think that by expecting——

Senator ROCKEFELLER. Yes. But are we not talking about how many, 84?

Ms. ALLEN. On the Part B side. Paul, how many?

Mr. DENNETT. There are about 48 on the Part B side. And altogether, with the Part A, makes it about 80.

Ms. ALLEN. Yes. Total. But not all contractors handle both A and B.

Senator ROCKEFELLER. Right. But some do.

Ms. ALLEN. Yes.

Senator ROCKEFELLER. And I am trying to figure out your statement about the hassle factor for the patients and the local knowledge. I mean, how local can one be, let us say, if one is doing, in effect, a State? How much individual knowledge of patients can one have? I am just trying to stretch you a little bit.

Ms. ALLEN. Well, I understand. Let me put it this way. I think for the State of Arkansas we had something like 5,700 Medicare patients come to our office in Little Rock, or that we met with within that State to help them with questions that they might have. They also, of course, many of them, have local lines in to us.

And I guess that is one of my concerns when claims are being processed elsewhere, how easy it is going to be for them to have that same type of service. And I suppose there are certainly ways to handle that.

On the other hand, I would like to make it very clear. I think that if, indeed, there are some economies at handling claims services through, perhaps, some consolidations, then I am supportive of that. I think what we have done in Louisiana, Senator, is a good example of that. We are the contractor for Medicare B in Louisiana; we also handle it for Arkansas.

But we have an office in Louisiana, we are furnishing employment to Louisiana citizens, and we are servicing those Louisiana beneficiaries and physicians with on-site staff. And I expect that is my biggest concern about it.

Senator ROCKEFELLER. Bill Toby, who was here earlier, said that he wants to establish an incentive to providers to use electronic claims billing. And my question to you is, is this something which is necessary, the incentive, or is this something which this conversion is probably going to take place anyway?

Ms. ALLEN. I will speak, again, for the area that we handle, although I think that this runs fairly well true nationally. We, right now, in our Part A operation, are getting something in the neighborhood of 86 percent of all of our Part A claims electronically, and on the physician's side for both Louisiana and Arkansas it is running in the low 50's. I would expect that by good marketing and badgering to some degree, we will see some increases in electronic submissions.

I think what we are down to, though, with electronic claims are the smaller office, single physicians, or a couple of practicing physicians that simply have a little bit of a problem trying to justify going the electronic means, even though the technology is very cheap and there are even things that we can do to try to encourage that even further. It still becomes a problem.

There is no incentive, as I see it, at this point actually for those physicians out there submitting via paper to go electronically. The claims are not going to be paid for at least 14 days, regardless of whether they are submitted electronically or whether they are submitted hard copy.

And I think that the real incentive would be to do away with that 14-day floor and say we are going to pay electronic claims within 3 days or 5 days.

And, as I understand it, I believe what the administration is proposing is to hold up hard copy claims for X number of days, but

go ahead and leave the 14-day floor in for EMC claims. I personally just do not think that is going to be a big enough incentive.

Senator ROCKEFELLER. Let me say to both of you that you have been very good witnesses, in the sense that you have been very forthright and blunt in your answers, and I appreciate that.

Ms. ALLEN. Thank you very much.

Dr. SPALDING. Thank you.

Senator ROCKEFELLER. Thank you both very much. Then our final panel will consist of Linda Aukett, who is here on behalf of the Coalition for Quality Home Medical Equipment Supplies and Services, and also Corrine Parver, who is president and chief executive officer of the National Association of Medical Equipment Suppliers. And you could both introduce your colleagues, perhaps.

STATEMENT OF LINDA AUKETT, CHAIRMAN, GOVERNMENT AFFAIRS COMMITTEE, UNITED OSTOMY ASSOCIATION, ON BEHALF OF THE COALITION FOR QUALITY HOME MEDICAL EQUIPMENT, SUPPLIES, AND SERVICES, WESTMONT, N.J., ACCOMPANIED BY CRAIG JEFFRIES, EXECUTIVE DIRECTOR, HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

Ms. AUKETT. Thank you. Good afternoon, Mr. Chairman. My name is Linda Aukett.

Senator ROCKEFELLER. Could you introduce your colleague, just so I know?

Ms. AUKETT. Certainly.

Senator ROCKEFELLER. Your colleague does not have a name, as far as I am concerned.

Ms. AUKETT. This is Craig Jeffries.

Senator ROCKEFELLER. All right. Good.

Ms. AUKETT. My name is Linda Aukett, and I am volunteer chairman of the Government Affairs Committee of the United Ostomy Association.

The UOA is a 42,000 member group, 90 percent of whom are individuals who have had ostomy surgery. Sixty to 70 percent of our members are Medicare eligible, as are many of the approximately 700,000 Americans who have undergone ostomy surgery. Most of them are affected by our discussion on the Medicare home medical equipment benefit.

I personally had ostomy surgery 22 years ago to cure a chronic, inflammatory disease. I have an ileostomy, meaning that my intestinal system ends at the ileum, or small intestine.

Wastes are collected in an inconspicuous plastic pouch which adheres to my abdomen. Thanks to this product of the HME industry, I am able to work and I have a very active lifestyle.

I am here today serving as spokesperson for the Coalition to Support Quality Home Medical Equipment, Supplies, and Services, or the Home Care Coalition. Appearing with me on behalf of the coalition is Craig Jeffries, who is Executive Director of the Health Industry Distributors Association.

The Home Care Coalition's primary goal is to focus on the well-being of home care patients by advancing the concept that home care is a vital component of a cost-effective health care delivery system.

The Home Care Coalition is comprised of organizations whose members are touched by home care, ranging from consumer organizations, to health professionals, to provider groups.

The coalition was formed early in 1991 in response to the need to communicate the positive aspect of home medical equipment, supplies and services.

Home care companies have put into place in the last 10 years a level of performance which has helped beneficiaries and professionals achieve confidence in the quality and availability of home care.

There was and is a need to clearly communicate to members of Congress and health policy makers that cuts in the Medicare Part B durable medical equipment benefit will adversely affect Medicare beneficiaries and the integrity of our entire health delivery system.

We submit for the hearing record the coalition's written testimony. My oral remarks will focus more specifically on opportunities to improve administration of the Medicare program.

The Home Care Coalition supports the efforts of Congress, the Health Care Financing Administration, the Office of the Inspector General, and the General Accounting Office to identify and focus resources to combat abusive and wasteful practices affecting the home medical equipment and long-term care supplies benefit. Often, such practices result from unnecessary complexities of the Medicare program, particularly the administration of the home medical equipment benefit.

Fortunately, HCFA is implementing a number of reforms recommended by Congress which will directly address problems that have encouraged questionable practices of some suppliers, such as carrier forum shopping.

The coalition supports the even stronger supplier number reforms included in Senator Cohen's legislation, and similar provisions of Senator Sasser's Medicare Durable Medical Equipment Patient Protection Act of 1991.

While the coalition supports the need to eliminate the opportunity for abusive and wasteful practices, we are concerned that new Congressional HCFA and OIG proposals be carefully targeted to address the abuse and not adversely impact the ability of Medicare beneficiaries to receive timely and quality home medical equipment services.

The existing support services that are incorporated into the Medicare home medical equipment services benefit are absolutely essential to assure the timely availability of quality HME services.

These support services range from timely delivery, set up, and education for the beneficiary and their family to technical, logistical, and paper work support for the hospital discharge planner and the prescribing physician, to the supplier's availability in inventory of the wide variety of products which patients need in the home.

UOA members are able to maintain active and productive lives, just as with many with long-term medical needs. Yet, they remain tied to the health care system to obtain the critical prosthetic supplies and essential support services.

Clearly, the home medical equipment services benefit is a valuable and integral component of the Medicare system and currently

meets the long-term care needs of many beneficiaries, including those in my UOA family.

Mr. Chairman, I want to highlight the coalition's concern with a new administrative procedure that may become a barrier to beneficiaries receiving covered home care services. That is, physician completion of a Certificate of Medical Need.

UOA members have repeatedly run up against an administrative nightmare owing to the frequency with which their supplies must be purchased. For example, because some carriers have failed to keep adequate medical necessity records, repeated denials of claims occur on the basis of lacking proof of medical need.

The beneficiary must continually request a new CMN from the physician. Some simply give up on trying to obtain the reimbursement to which they are entitled.

The physicians with whom ostomy patients interact the most is the surgeon, whose professional time is most effectively spent in surgery. We do not expect them to know all the details concerning the equipment itself: the brands, the sizes, the wear time, and so on. Moreover, physicians have no professional or financial incentive to accomplish this administrative chore.

Prior to the OBRA–90 provision, the supplier would take administrative responsibility in coordination with discharge planners, home health agencies, and other professionals to complete the information on the CMN and forward it to the physician who verified the information and attested to the medical need for those items. This was a much more efficient and predictable division of responsibility.

The Home Care Coalition recommends that the administrative burden for filling in the CMN fall on the physician only in the case of abused or over-utilized items.

That is, fine-tune the OBRA–90 provision to achieve administrative efficiency while effectively targeting abuse. This is the approach in Senator Cohen's bill.

The Home Care Coalition is happy to work with the committee and its staff in further developing legislation that would accomplish these objectives. Thank you.

Senator ROCKEFELLER. Thank you, Ms. Aukett.

[The prepared statement of Ms. Aukett appears in the appendix.]

Senator ROCKEFELLER. Dr. Parver.

STATEMENT OF CORRINE PARVER, J.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS, ALEXANDRIA, VA

Dr. PARVER. Thank you, Mr. Chairman. With me is Jim Liken, who is a member of NAMES' Board of Directors and operates facilities in your home State. I thought you would enjoy meeting him and hearing a few words from him today.

As you know, the home medical equipment (HME) services industry which is just 2 percent of overall Medicare outlays—some $2 billion—plays a key role in our nation's health care system.

It is a proven, cost-effective method of providing needed care to Medicare beneficiaries in their homes and enhances the quality of life for recipients such as Ms. Aukett, and their families.

But, despite the critical role that HME plays in completing an individual's acute care episode and in long-term care, HME continues to be singled out for significant payment reductions, ostensibly because of numerous reports of fraud and abuse, some of which we heard earlier today.

But I submit to you that to address the problem of abusive business practices, the proper response should be to target the abusers. Reducing HME reimbursement across the board does nothing to punish the abusers or extricate them from the Medicare system. Moreover, it punishes the legitimate, ethical suppliers for the sins of the few.

For this reason, I urge you to give serious consideration to the comprehensive HME ethics legislation that NAMES helped develop: H.R. 2534 introduced by Representative Ben Cardin in the House, which currently has 108 co-sponsors.

Several provisions of that bill have been incorporated in a House Ways and Means Committee package that was marked-up on April the 1st.

Similar legislation is pending before your committee in the form of S. 1736, Senator Sasser's bill, and also S. 1988, Senator Cohen's legislation, the Quality in Medical Equipment and Supplies Act of 1991; in both of those bills NAMES worked very hard to ensure certain provisions were put into the legislation.

We recognize the advantage of tightening requirements for obtaining supplier certification through a stricter provider number application process. This is envisioned in S. 1988. The current system under which such numbers are issued with little or no scrutiny of business practices or quality of care absolutely needs revision.

S. 1988 also contains a provision extremely important to physicians and suppliers alike. Current Medicare law prohibits suppliers from completing any part of the claims processing document called the Certificate of Medical Necessity that is required by HCFA to show medical necessity.

S. 1988 and H.R. 2534 both contain similar provisions which would restrict and target the CMN completion prohibition where the need truly exists, and that is on specific items which HCFA determines are subject to abuse or over-utilization.

That is the kind of appropriate policy rationale that we believe is needed to reduce waste and fraud in the Medicare program.

Another important way to streamline Medicare administrative costs is to enact a first-month lump sum purchase option for specific items of HME, such as certain wheelchairs where it is clear from the outset, either through a physician's diagnosis or other objective standards, that a patient's need is permanent or long-term, the Medicare beneficiary should be entitled to purchase equipment right from the start.

The present system incurs needless administrative burdens on Medicare carriers through processing monthly rental claims. NAMES urges you to amend S. 1988 to allow for such a purchase option.

As an aside, I respectfully suggest that any discussion about Medicare waste should not focus solely on provider abuse. Medicare cannot operate efficiently without private contractors, such as car-

riers. When a carrier commits fraud or abuse, harm to the program also can be substantial.

On April the 17th of this year, the Department of Justice announced its intervention in a law suit against a carrier, Florida Blue Cross/Blue Shield, alleging violations of the False Claims Act from 1986 to the present, stemming from a scheme to defraud Medicare.

The law suit contends that claims were mishandled and not processed as required by Medicare regulations—and I am talking about claims for home medical equipment.

If Medicare does not have reliable data from its own contractors, how can it possibly go after alleged supplier abuses in an appropriate and targeted fashion?

We do not even know what data HCFA maintains separate from these contractors in order to know whether the information that contractors are maintaining is accurate.

Carriers are paid millions of dollars to process claims accurately and timely. The criminal investigation in this law suit has been going on for two and a half years, yet HCFA continues to renew this particular carrier's Medicare contract.

And this carrier has been awarded new Federal Government contract responsibilities throughout this time period. Issues of this sort have to become part of the focus on health care abuse.

I would now like Jim Liken to say a few words.

[The prepared statement of Dr. Parver appears in the appendix.]

STATEMENT OF JIM LIKEN, PRESIDENT, LIKEN MEDICARE CENTER, PITTSBURGH, PA

Mr. LIKEN. Senator, I am a service provider of home oxygen and home medical equipment in Western Pennsylvania and Northern West Virginia. And I would like to just take a minute to describe to you what my operation is like and what it looks like in Wheeling, WV.

We have a store front in the Omgrove Crossing Mall. And in that you would find hospital equipment, wheelchairs, and bath safety aids on display for people to look at and understand.

In the back you would find a warehouse, and behind that we have four delivery trucks where we deliver equipment into 10 counties in West Virginia.

The employees are local. They are members of the community. The health care professionals and physicians respect us as part of the health care team.

When we get a physician's order for equipment, my customer service people instantly call the physician or their office to make sure that we know what they want to do with that patient and their equipment. We are an integral part of the community.

I know a lot of people in the area, and very many parts of the area are now being served by just one equipment provider because of some of the cost reductions over the years.

I say this because when I hear of mail order type supply houses and telemarketers, I get incensed. It just does not make sense. I do not consider them a home medical equipment provider, and I want them out of the business. I personally will pledge my support to do anything that I can to accomplish that.

I am also here if you want to ask some questions about specifics with patients or equipment. I guess I am the reality check from Wheeling, WV.

Senator ROCKEFELLER. All right. Thank you all. Whoever wants to answer this can do so. Your organizations have been instrumental in establishing criteria for suppliers to qualify for a Medicare provider number. These standards will certainly allow beneficiaries and professionals to be more confident about the quality of home care services. Do you have any idea as to what percentage of providers meet these standards?

Dr. PARVER. There are several companies who have undergone accreditation already. There are two accrediting organizations who, to date, have accredited over 700 suppliers. We have over 2,000 suppliers in our organization.

So, in order to meet the criteria for accreditation, because there is no certification yet, or licensing in the industry, the only measurement tool we have is accreditation. The Joint Commission on Accreditation of Health Care Organizations, for example, has very strict home care standards that check the quality of care, services, and equipment that is provided to the patients that are serviced by the home care suppliers. I know Jim Liken's company is accredited.

Mr. LIKEN. There are four home medical equipment providers in Wheeling, WV, and all four of them are JCAHO accredited.

Senator ROCKEFELLER. All right. Mr. Toby, in his testimony, is recommending specifically that we expand the prohibition of suppliers completing CMNs to include prosthetics, orthotics, and medical suppliers. Since you oppose many of the current CMN prohibitions, I am interested to know and do suspect that you oppose this recommendation as well. Could you tell me if you do, why? Any of you.

Dr. PARVER. The National Association of Medical Equipment Suppliers believes that the way to control abuse is to target the abusers.

Senator ROCKEFELLER. And what do you mean by that?

Dr. PARVER. The items of equipment that have been known and documented to be over-utilized are characterized already in a list by the Health Care Financing Administration.

For those specific items we strongly believe that physicians should complete the entire form—equipment such as seat lift chairs where HCFA and the carriers have tracked over-utilization.

But, for ordinary pieces of equipment such as canes and walkers, it does not make sense from an administrative burden and cost point of view to have the physician complete the Certificate of Medical Necessity. The physician always should sign the form, but the suppliers should help in providing the accurate information.

In other cases, such as, for example, customized wheelchair equipment where the seat and the back have to be molded specifically to meet a person's deformities, truly—and I am not saying this in a disparaging way—the physician who takes care of the patient does not really know or understand seating systems the way the Rehab Technology Supplier understands them. They cannot be expected to know all parts of the Medicare program in such detail.

Those kinds of Certificates of Medical Necessity should be completed by the supplier, but then, of course, submitted to the physi-

cian for review and for signature. There must be that control by the physician who orders the equipment.

Senator ROCKEFELLER. But do you not see the credibility problem there? I mean, I can understand what you are saying. But, in fact, is it not just odd—and I am trying to think of other things where this happens where the people who actually make the products and sell the products write out the prescription for those products. And then the physician or some comparable person is asked to sign that.

Obviously, some of these physicians would be under peer pressure in the sense that they might not have seen this person in several months and they figure, well, something had come up and they just did not know about it, or whatever. But it is not sort of philosophically odd to have the folks who produce and market to actually write the prescription?

Dr. PARVER. Well, the physician originates the order always, verbally, when the patient is in the hospital. For example, with oxygen, a physician may order the oxygen equipment to help the patient return to the home and then stay in the home. So, it always originates with the physician.

Mr. JEFFRIES. And I think it is important to understand the terminology differences. A physician prescribing just takes a very short action by the physician. He determines that there is medical need and he says, I want to have the appropriate equipment. The Certificate of Medical Necessity is a form with over 20 questions in it.

So, what we are talking about here is not the decision whether or not a patient has medical need for the product, it is putting the package of information related to the duration of need, the type of product, and all those sort of things into a form that HCFA wants to review, and appropriately should review.

And I think there is a balance between who are the appropriate players that have the expertise to add that information, and then who has the appropriate expertise to review that information? The physician is always controlling the final document by signing it and verifying information.

It is just a question of who he can rely on to put the information into it in a format beyond his prescription decision for medical necessity that HCFA wants to review for not only medical necessity, but all the other coverage criteria.

Mr. LIKEN. Senator, may I comment on that?

Senator ROCKEFELLER. In a minute. The whole question of wheelchairs and sort of the unbundling of the various parts of wheelchairs and they were sold. Somewhere I was reading this, perhaps in my preparation for this, that they are broken down into many different parts and they are sort of unbundled, so to speak, and then billed differently and the costs arise.

Now, the whole context of this is, and nobody seems to deny it, and you all do not because you say that it is going on within your own profession, what you want us to do is for us to target who those people are, that billions of dollars are at stake here. The economy is running out of steam, the American people have run out of patience.

And those of us in government who are looked to try to maintain rectitude and all of the rest of it in terms of how government money is spent, I mean, that is our job. That is not your job, that is our job. We have to oversee it. We have done very little in this committee, and that is the subject for another meeting with other people.

But evidently a number of the folks in your business, the ones who you want to target, have really made a killing on this and have ratcheted up the prices enormously.

This is not just today, this is something we have heard in the past. I have met individually with DME people in West Virginia on occasion and we have talked about this kind of thing.

When you say, do not change the system, do not have HCFA or the physicians fill these things out, let us do it, but go ahead and target the people who are doing this wrongly, how is it that you expect us to target those people? What are you all doing about that?

Mr. JEFFRIES. Senator Rockefeller, a lot of the answers to that question are contained in the package of recommendations that, for example, Janet Shikles from GAO commended, that HCFA is proceeding on: the improvements on the supplier number so that an individual company has one supplier number, the consolidation of carriers so that a carrier, instead of 5 percent of their processing will be DME, 100 percent will be DME. They will have greater expertise to manage that area of their operations.

These are reforms that go hand in hand with all of the other things that we are trying to do to improve the integrity of the processing for the home medical equipment benefit.

So, the OBRA–90 provision and the CMN has to be seen with the other recommended changes that are actually going into place that are addressing components of the problems that this is only one piece of.

Dr. PARVER. In addition, NAMES has created a Code of Ethics for the industry, a Guide for Conduct, a Statement of Patient Rights and Responsibilities.

We have produced several consumer education brochures so that the consumers should know what to look for if someone telemarkets in a certain way, so that they should be careful to check and see whether a supplier is accredited, for example, which would be one way they can assure a certain level of quality.

So, the industry is doing its share of trying to control fraud and abuse. But what we need is for you to help us out by controlling who can become a provider.

At this point, there is no control. Anyone who applies for a Medicare Part B provider number can get one, pretty much. So, we are asking for stricter controls on that. That needs legislation. We are asking for reducing the number of carriers.

Although it was within the discretion of HHS and HCFA to reduce down from 34 carriers to however few they wanted—that authority was granted in the 1987 OBRA when the Six-Point Plan for paying for DME was enacted—they never acted to reduce the number of carriers, and it was really the Medicare program that allowed this carrier shopping process to occur.

NAMES, in 1987 when OBRA was being discussed, came to Congress and asked for a restriction in the number of carriers. At that point, we requested 10 carriers; one for each HCFA region.

Congress gave HCFA the authority, but did not require it. As a result, you had all of these years from 1987 to the present time of this practice of carrier shopping where you could shop around for the highest price. When we went forward to Representative Ben Cardin in the House and asked him to put this in his legislation to restrict the number of carriers, he agreed.

And it was not until then that you had the response from HHS and HCFA in saying, all right, we think that is a good idea, once their feet were put to the fire, so to speak, and came forward with this proposed rule to restrict the number of carriers to four. Well, it is a day late and a dollar short.

Multi-millions of dollars for seat lift chairs alone were paid through one carrier in Ohio, with no one looking forward through the claims to see whether or not it passed the "Snell" test.

So, what I am saying to you is we need your help. We have done certain things. We need your help to pass the legislation.

Senator ROCKEFELLER. You were going to say something, Mr. Liken?

Mr. LIKEN. I wanted to refer back to the complexity of the physician's prescription and the documentation necessary. I brought a case with me that is a low air loss therapy bed that we delivered on November 7, 1991.

And that is the type of product we need a prescription prior to delivery, so the physician wrote that prescription. We followed it up to get the formal Certificate of Medical Necessity.

We also need additional documentation to prove that that individual had Stage IV decubitus, which is an open bedsore, so that they can leave the hospital and go into the home.

We delivered the equipment. On February 1st we got a letter from the carrier that asked us for additional documentation. We went out and got 44 pages of additional documentation from the physician and the home health agency that happened to be in on the case.

We got a letter in March that say they are now processing the claim. We got a letter April 30th denying it because they wondered whether the physician was actually supervising the case.

Forty-five pages of documentation. How much do we need? How much does that doctor have to deal with? How much does the supplier have to deal with? This is the type of thing we have to make sense out of for all of us.

And just a couple of facts on how it affects me as a businessman. Forty-seven percent of my insurance billings are Medicare, and 63 percent of my insurance accounts receivable are Medicare.

Seventy-nine percent of receivables I have over 90 days are involved with oxygen or low air loss therapy where the carrier is demanding additional, and additional, and additional information, ad infinitum, that just slows down my collection processes enormously. And it becomes a cash crunch for a small businessman.

Mr. JEFFRIES. Another important factor, Senator Rockefeller, from a broader policy perspective that was brought up by Mr. Liken's comment, and that is, we are talking about initiation of

home care services. And those are largely after the discharge from a hospital.

So, right now, what is happening, and the case Mr. Liken described is a little bit different, but in most cases the patient is discharged to go home and is receiving services in the home, while all the paper work tries to catch up with them. So, the supplier is at risk for the physician properly filling out this 20 or 25 question form for approval by Medicare.

And, in fairness to any business, if you are going to take the responsibility away for that payment, that accounts receivable, by giving it to the physician, the logical policy conclusion would be, all right, you keep the patient in the hospital until the paper work is ready to discharge the patient home with assuredness of payment.

And, clearly, that is not going to save us money on the much higher expenses in the hospital. So, there is a lot of balancing there.

Senator ROCKEFELLER. Let me ask two final questions for the record to whoever wants to answer this. Mr. Toby is recommending that we allow purchase rather than rental of nebulizers and aspirators. Do you favor the recommendation? Can you explain to me the advantages and disadvantages of rental for any home medical equipment?

Mr. LIKEN. I would like to answer that on two levels. The first one is what is commonly called a pulnioaide, a nebulizer. Our company protocol right now has a respiratory therapist delivering that piece of equipment. That piece of equipment delivers medications prescribed by a physician into a patient's lungs.

Our therapist sits down with the patient and instructs them in the use and makes sure that they understand their treatment and they can go from there. The therapist does a follow-up every month with that patient, and if they need additional training, we give it to them. So, that is the protocol as it is.

If the nebulizer goes for purchase, the protocol will change to the fact that you just hand the patient the machine and they will buy it. Either way could be all right.

There is also a third category that it could go into, which is the capped rental category, which no one seems to talk about. But there are three different ways of handling that. Three different service levels would accompany that.

The second item is the wheelchair, should it be purchased or not? My average patient that I have is probably 85 years old. They are going home to die. They are going to have that wheelchair 5, 6, 7 months, on average. That is about what it is.

So, the program gets a very, very good deal out of renting that equipment. Some of those patients rent it for a month, some rent it for 24 or 30 months; it depends on how long they are going to live.

There is a different kind of patient, the patient that is a Medicare patient that needs a wheelchair for the rest of their lives, but they are going to live for 5, 10, or 20 years.

I have an example that I brought with me: A fellow who is a paraplegic. He is 32 years old and on Medicare, and he will live another 35, 40 years. He got denied for Medicare, Medicare will not

buy him a wheelchair. He got a letter from them that said they will rent it only.

This is a clear-cut case of someone who should be purchasing a wheelchair. So, there are different facts, and we have to accommodate those different things.

Senator ROCKEFELLER. All right. That is fair enough. Thank you for your patience in waiting as long as you did, and for the helpfulness of your responses.

[Whereupon, the hearing was concluded at 5:27 p.m.]

APPENDIX

Additional Material Submitted

Prepared Statement of Sharon K. Allen

Mr. Chairman and members of the subcommittee, I am Sharon Allen, Executive Vice President of Government Program Services for Arkansas Blue Cross and Blue Shield. I appreciate this opportunity to discuss our role as a Medicare intermediary and carrier.

As you requested, my statement focuses on our activities to safeguard Medicare from inappropriate or unnecessary payment for services. I will also discuss our efforts to prevent Medicare fraud and abuse. Finally, I want to share with you our continuing concern about the lack of sufficient funding for these important operations.

From the start, the federal government turned to us and other Blue Cross and Blue Shield Plans to help manage Medicare benefit payments. Arkansas Blue Cross and Blue Shield has been part of the administration of Medicare since the program's inception in 1966. In the state of Louisiana, we have been processing Medicare Part B claims since 1984. For 29 other Medicare contractors, we also provide claims systems support services through cooperative agreements. Last year, we processed nearly 13.5 million claims for almost 900,000 Medicare beneficiaries and we saved the federal government $98 million by preventing inappropriate payments.

In recent years, this partnership with the federal government has been strained. The benefits provided by Medicare have increased along with the volume of claims and the complexities of the program have increased enormously while the willingness of the federal government to provide the resources needed to manage the program has been constricted.

As a result, the role of contractors has become more of a bill paying activity and less emphasis has been placed on the management of Medicare benefits. Clearly, this imbalance needs to be addressed if we are to ensure that Medicare dollars are spent properly. We could be doing much more to manage the program more effectively and to detect and reduce fraud and abuse if the federal government committed the necessary funds to those activities.

We know first hand of the worth of program safeguards activities from our private business experience. In our business, we are aggressive innovators in managed care, medical review, and customer cost containment activities. We also recognize the importance of Medicare's efforts to prevent inappropriate or improper payments for health care services and that these efforts help directly to control our national health care bill.

Despite the current funding problems, we believe that the partnership between Medicare and its network of contractors has served the program well over the last two decades. Through this network, Medicare has been able to maintain an enviable record of administrative efficiency, particularly considering the program's size and complexity. Generally speaking, our administrative expense is under 2 percent of benefit payout. And, by preventing improper or inappropriate payments, contractors provide over $4 billion in savings to Medicare each year, more than the cost of Medicare's entire administrative budget. Now, let me discuss our payment safeguard operations more directly.

Medicare contractors have three basic payment safeguard responsibilities. First, claims are reviewed to determine if the services provided were medically necessary and appropriate. Second, there is the audit program which involves reviewing the financial records of hospitals and other health facilities to prevent wrongful billing and to ensure the proper allocation of costs. And third, collections are made from

employer group health plans when they are determined to have the primary payment responsibility for health claims and Medicare is the secondary payer.

These operations have consistently achieved impressive savings for the federal budget and the American taxpayer. In fact, few, if any, government expenditures produce such hard, documented savings each year as are generated by Medicare's payment safeguard activities.

For FY 1989, when the payment safeguards budget of $358 million was the highest ever appropriated, the Health Care Financing Administration (HCFA) reported that with a payment safeguards budget of $358 million, Medicare contractors achieved $3.96 billion in benefit savings, a return of over 11 to 1.

Four years later, with funding below the FY 1989 level, payment safeguard returns for FY 1992 are still projected to be approximately $4 billion while total expenditure on Medicare have increased by over 60 percent during the same period. Without a doubt, funding is the single most frustrating issue with which we deal, but it is not just the amount of funds available. We are also concerned about the timing of funds released to contractors and the tight restrictions placed on their use. We are pleased the Administration's FY 1993 budget recommends a significant increase in payment safeguards activities, but the tight budgetary constraints facing the Congress this year make this increase anything but certain.

But the savings themselves are only part of the picture. Ultimately, the goal of the payment safeguards structure is to assure that Medicare funds are spent as intended by Congress for medically necessary and appropriate care and only when the trust funds have an obligation to pay. Moreover, these operations have an essential "sentinel effect" by sending a strong signal that Medicare is serious about being a prudent and vigilant payer for health care services. Next, I would like to briefly describe how these payment safeguard operations work.

MEDICAL REVIEW

Medical review activities assure that the services provided to Medicare beneficiaries are medically necessary, appropriate and covered by the program.

To perform these operations, prepayment review of claims is conducted based on national and local "screens" to flag services that may not be medically necessary.

For example, more than one physician visit per month to a patient in a skilled nursing facility would not be considered medically necessary absent documentation explaining the condition or symptoms warranting the additional visits.

Postpayment audits of claims are also performed to identify patterns of potential over-utilization, fraud, or abuse when compared with peer group norms. In addition, staff in this area educate providers on issues of coverage, billing practices and expected patterns of care. We believe that our provider education efforts are particularly important and help prevent inappropriate billing.

Many contractors' medical review operations are conducted by a team of reviewers including licensed practical nurses and registered nurses who conduct most of the "hands on" review effort. We also have a Medicare medical director, a practicing physician who is responsible for recommending and approving new medical review policies and acting as a liaison with the provider community.

In difficult cases where medical necessity or appropriateness are at issue, the medical director also serves as the ultimate arbitrator of payment decisions.

HCFA expects that these medical review activities will save Medicare $1.1 billion in fiscal year 1993. Even more important than the reported savings however, is the deterrent effect that a vigorous medical review operation has by making it known that Medicare payments will be made only for medically necessary services.

AUDIT

The Medicare audit function represents the final opportunity for Medicare's fiscal intermediaries to review program expenditures for hospitals, skilled nursing facilities (SNF), and home health agencies (HHA).

The audit function involves scrutinizing a health care facility's "final billing" for services to ensure that only legitimate costs are paid and that Medicare is protected from costs which are unreasonable, unnecessary or illegal.

Even after the introduction of the prospective payment system (PPS), there are still significant areas where Medicare payment is based on actual costs. Further, the audit of provider cost reports is the primary means to maintain the integrity of Medicare Part A program payments and the foundation for sound policy decisions on needed payment adjustments. Last year, we as the Arkansas Medicare contractor, saved the program over $15.5 million through these activities.

Many of these responsibilities closely resemble those of the Internal Revenue Service and, like the IRS, involve many of the same skills and training for the audi-

tors. The audits are directed at those areas in the cost report which have been determined to be the most likely to be misstated and thus result in saving to the program.

Starting this year, audits have almost entirely been limited to those necessary to blend capital costs into the prospective payment system. This activity has come at the expense of virtually all other audit activity which is focused on preventing wrongful billing. There will be very little, if any, Medicare costs recovered through the audits of capital expenses, and Medicare will forego the savings from normal audit activity.

As a result, at least 75 percent fewer hospitals will be audited this year compared with 1991 for bills submitted to Medicare. In fact, the losses to the Medicare trust funds may be exacerbated by the reduction of the "sentinel effect" of normal audit activity.

MEDICARE SECONDARY PAYER

The third, and final, payment safeguard is the Medicare Secondary Payer (MSP) program. The purpose of this program is to ensure that Medicare payments are not made for services provided to beneficiaries who have other coverage that is primary to Medicare. We view the MSP program as a coordination of benefits activity which saves the Medicare program money by identifying the primary payer of health benefits.

Among the other payers whose coverage may be primary to Medicare are employer group health plans covering the working aged and spouses, disabled and ESRD patients as well as auto, liability, workers' compensation, and no fault insurance programs. The MSP programs is extremely cost efficient, realizing savings of approximately $35 for every dollar invested and accounting for over $2 billion in direct savings annually to the trust funds. Changes in the MSP program were enacted by Congress in the Omnibus Budget Reconciliation Acts of 1989 and 1990.

A data match has been established to identify Medicare beneficiaries or their spouses who have health coverage through an employer group health plan based on information obtained from Internal Revenue Service (IRS) and Social Security Administration (SSA) records. In April, HCFA began to distribute lists to Medicare contractors of payments which should have been made by the employer plan instead of Medicare. Medicare contractors will be responsible for recovering any erroneous payments and modifying their claims processing systems to prevent Medicare from paying future claims that should be paid by others.

We support these program improvements, but we also agree with recent reports by the GA0 that the immediate effect of the data match will be a large increase in backlogged MSP cases that will be very difficult to, resolve without an equally significant increase in administrative effort and funding.

The recovery project for these claims will be very labor intensive. While significant returns are anticipated, we are concerned that the level of funding may not be sufficient.

PREVENTING FRAUD AND ABUSE

Medicare contractors have important responsibilities in detecting and preventing fraud and abuse. Beneficiaries frequently bring cases to our attention by informing us when Medicare has been billed for services that they did not receive. More often, our payment safeguard operations lead us to suspect instances of wrongdoing which are then investigated further.

Examples of these types of practices include:

- double-billings and inflated billings;
- kickback schemes for making patient referrals or signing false treatment plans;
- submission of costs for which Medicare payment is excluded; and
- false information about a patient's condition to qualify for benefits.

Many of these cases require months of meticulous review in order to validate the alleged instances of fraud. Guidelines developed by the Office of the Inspector General (OIG) are used to refer cases for possible disciplinary action, including financial sanctions or suspension of providers from further Medicare payments.

After the OIG has taken such adverse actions, contractors are required to ensure that no payments are made to the excluded providers according to the terms of the judgment.

This effort to detect and eliminate fraud, abuse and waste in the Medicare program is a cooperative effort involving beneficiaries, contractors, peer review organizations, State Medicaid agencies, and Office of the Inspector General (OIG).

Our primary role is to identify instances of suspected fraud or abuse and refer them to OIG for consideration and application of criminal or civil monetary penalties or administrative sanctions actions. The Administration has proposed in its FY 1993 budget a separate $24 million fund for fraud and abuse detection efforts of Medicare contractors. This is the first time that specific funds have been identified for this purpose within the overall payment safeguards program. We support the Administration's increased emphasis on detecting fraud and abuse in the Medicare program.

BUDGETARY TREATMENT

We believe that because of the budget constraints imposed by the Budget Enforcement Act of 1990 (BEA), the administrative budget for Medicare will continue to be at risk for "penny wise and pound foolish" underfunding problems.

As the domestic discretionary spending caps place a tighter squeeze on the dollars available to protect the Medicare program, administrative costs must compete with a large number of deserving programs. In that competition, administrative costs have tended to come in second place.

The General Accounting Office (GAO) continues to issue reports alerting Congress to the billions of dollars lost to the Medicare trust funds because of inadequate Medicare administrative dollars. In February 1992, GAO issued a report stating that $1 billion dollars in Medicare overpayments to hospitals were not being collected because Medicare contractors lacked sufficient funding to pursue the accounts.

In that report, the GAO again recommended additional funding for Medicare contractor activities. They also proposed that the spending caps established by the Budget Enforcement Act be adjusted for the funds provided for this purpose. This same approach was established in 1990 for funds provided to the Internal Revenue Service (IRS) for administering the collection of taxes, recognizing that increased administrative effort results in additional revenues being collected.

Three bills recently introduced by Senator Harkin (S. 2713), Senator Grassley (S. 2337) and Congressman Rostenkowski (H.R. 4805), are based on this GAO recommendation and would help to ensure adequate and stable funding for these activities. Because the services of Medicare contractors, like the IRS, are highly cost-effective, these bills would allow Medicare administrative activities to be funded up to a specified maximum amount each year. Budget spending caps would then be adjusted for appropriations provided within this limit.

The Harkin and Rostenkowski bills would allow Medicare contractor funding to increase by 11.6 percent each year the same amount as the volume of Medicare claims has increased for the past several years. The additional funds would be available for the full-range of Medicare contractor activities, including the payment of claims, services to beneficiaries and providers and the payment safeguards programs.

The Grassley bill is similar to the other two bills but, the additional funds would be available only for payment safeguard activities. We support these bills to improve the administration of Medicare and we believe that changes in the budget process are an essential part of that effort. We look forward to working with the sponsors of these bills and this subcommittee on these initiatives.

CONCLUSION

Clearly, we believe that the payment safeguards efforts of Medicare intermediaries and carriers are among the best investments made by the government and are essential to the sound management of its health care dollars. Our private sector leadership and experience in holding down health care costs and ensuring that payments are made only for appropriate services has much to offer Medicare.

We are committed to strengthening our partnership with Medicare to ensure that beneficiaries trust fund dollars are spent appropriately. We appreciate your continued interest and support for these activities and' we look forward to working with you to improve the administration of the Medicare program.

Prepared Statement of Linda Aukett

I. INTRODUCTION

A. Home Care Coalition

A Coalition to Support Quality Home Medical Equipment, Supplies and Services (Home Care Coalition) has been formed with a primary goal to focus on education

and communications to its members, policy makers and the public. The participants in the Home Care Coalition believe that in meeting its goals, the Home Care Coalition will contribute to the well being of home care patients by advancing the concept that home care is a vital component of a cost effective health care delivery system.

This Coalition was formed early in 1991 in response to the need to communicate the positive aspects of the Home Medical Equipment, Supplies and Services (HME) industry. There was and is a need to get the message to Members of Congress and health policy makers that cuts in the Medicare Part B durable medical equipment benefit will adversely affect Medicare beneficiaries. By working collectively, with a unified, broad based group of organizations, the Coalition can communicate information that will improve the understanding of the support structure that the HME industry has put in place.

Home medical equipment, supplies and services companies have put into place in the last ten years a level of performance which has helped beneficiaries and professionals achieve confidence in the quality and availability of home care. To that end, the mission of the Home Care Coalition is to preserve the Medicare Part B durable medical equipment benefit, to support quality home medical equipment, supplies and services, and to improve beneficiary access to these services.

To clarify and demonstrate the range and importance of support services provided by HME companies, individual association organizations participating in the Home Care Coalition asked their members—Medicare beneficiaries, hospital discharge planners, clinical practitioners—to provide first hand examples from their daily worklife of the value of these support services. Through these first hand reports, the Home Care Coalition demonstrates a model of home medical equipment services. This goal is similar to the goal of this Committee in developing provider number requirements that establish basic business, health and safety standards for HME companies that want to service Medicare beneficiaries.

We submit for the record at Appendix A a sampling of model practice letters collected by the Home Care Coalition. Later in this statement we identify suggested criteria and procedures for an improved Medicare provider number system.

B. Coalition Supports Congress' Efforts to Eliminate Abusive and Wasteful Practices, and to Protect Home Care as Integral to our Nation's Health Care System

The Home Care Coalition supports the efforts of Congress, the Health Care Financing Administration (HCFA), the Office of Inspector General (OIG) and the General Accounting Office (GAO), to identify and focus resources to combat abusive and wasteful practices affecting the home medical equipment and long term care supplies benefit. Often such practices result from unnecessary complexities of the Medicare program, particularly the administration of the home medical equipment benefit.

While we support the need to eliminate the opportunity for abusive and wasteful practices, we are concerned that Congressional, HCFA and OIG action be carefully targeted to address the abuse and not adversely impact the ability of Medicare beneficiaries to receive timely and quality home medical equipment services.

In the past, Congressional solutions to real or perceived problems have created difficulties of their own. For example, the modality-neutral method of oxygen payment reform enacted in the Omnibus Budget Reconciliation Act of 1987 has had a demonstrable impact reducing the availability of portable liquid oxygen and on the development of new cost-saving technology. Similarly, the broad payment reform for wheelchairs in the Omnibus Budget Reconciliation Act of 1990 appears to be reducing the beneficiary's ability to receive these items in a timely manner.

The existing support services that are incorporated into the Medicare home medical equipment services benefit are absolutely essential to assure the timely availability of quality HME services. These support services range from timely delivery, set-up, and education for the beneficiary and family; to technical, logistical and paperwork support for the hospital discharge planner and prescribing physician; to the supplier's availability in inventory of the wide variety of products patients need in the home. A July 26, 1990 report by Lewin/ICF, "The Home Medical Equipment Industry: An Examination of the Industry's Expense Structure," describes these services and their value to the Medicare program. A copy of this study is attached as Appendix B.

Also, a report on cost-effectiveness of home medical equipment services underscores the need for Congress to strengthen the availability of necessary HME services. In a study entitled "Economic Analysis Of Home Medical Equipment Services" (May 1991), Lewin/ICF analyzed three case examples: hip fracture, Amyotrophic Lateral Sclerosis (ALS) with pneumonia, and Chronic Obstructive Pulmonary Disease (COPD). Lewin/ICF concluded that savings of up to $2,330 per patient episode could be achieved, with annual savings potential of up to $575 million when home

medical equipment is used in conjunction with inpatient hospital treatment. A copy of this study is attached as Appendix C.

A large and diverse population relies upon home health care for a wide variety of medical reasons, and when given a choice, patients prefer to have their health care administered in the home. These are the results of a Consumer Research Study conducted recently by National Research, Inc. The Executive Summary of this Survey is attached as Appendix D.

II. PROVIDER NUMBER SYSTEM REFORM

A. Medicare Objectives for Provider Number Need to Change

The Home Care Coalition strongly supports a shift in the objectives of the Medicare provider number from simply a billing number to a viable system to establish certain criteria for suppliers to *qualify* to bill Medicare for items of HME provided to beneficiaries.

Currently, the Medicare program has each carrier issue provider numbers to companies that bill that carrier. Although carriers may have different requirements for suppliers to receive a provider number, no carrier that we are aware of has a system that ensures that suppliers receiving a number deliver an acceptable level of quality services, are a viable business, or even have ties to the community. There is no renewal procedure to update and requalify the supplier.

Every Medicare carrier currently maintains its own provider number records and develops its own application form. There is no consistency from one carrier to another, and HCFA does not require any national uniformity in carrier administration of provider numbers.

The current system which Medicare uses to issue and maintain provider numbers is fraught with problems, many of which are associated with program abuse and waste of federal dollars. Currently, carriers issue provider numbers with little or no scrutiny of the applicant's basic business qualifications. HME companies usually are not subject to state licensure laws, quality assurance standards or other health and safety standards typically required of health professionals, and that are designed to ensure that patients and beneficiaries receive services from qualified providers of care. The current provider number system is simply used to administer the paperwork associated with billing Medicare for HME and other Part B services.

B. Home Care Coalition Recommendation

Given the shortcomings of the current system, the Home Care Coalition strongly recommends that Congress direct HCFA to create a front-end screening program to establish standards as a prerequisite for suppliers to be able to deliver services to Medicare beneficiaries.. The new provider number system should have four components:

(1) basic business, health and safety standards
(2) business practice and ownership disclosure
(3) periodic renewal
(4) national administration

(1) *Basic Business, Health and Safety Standard:* Supplier number criteria must define basic business, health and safety standards which suppliers must meet to obtain and maintain a supplier number, and therefore to deliver services to beneficiaries. The criteria would be available to all supplier candidates prior to completion of an application for receipt of a supplier number. Suppliers would have to attest to the accuracy of the information in the application. Carriers would have to actively review the supplier's compliance with the criteria. A supplier should be deemed to have met these requirements either through state licensure or accreditation.

Pertinent health and safety standards should be required for certain services. For example, a supplier providing oxygen equipment and services should be required to meet criteria designed to ensure the supplier provides an appropriate level of safety and quality services associated with home patient use of such equipment.

(2) *Business Practice and Ownership Disclosure:* Business practice and ownership disclosure within the provider number application process would provide important information to allow the carrier, HCFA and the OIG to monitor potentially abusive practices more closely. For example, telemarketing practices by a supplier or physician ownership would be disclosed; and the carrier could monitor suppliers more closely to assure that their ownership and business practice does not cause abuse and is not abusive.

(3) *Periodic Renewal:* To ensure that only suppliers who meet basic business standards and who fully disclose business ownership information (i.e., meet provider number criteria) receive and maintain a valid current provider number, there needs to be a regular renewal process. Suppliers with "clean" records should be required to renew their number (update application Information or state no changes) every two or three years. Suppliers with questionable business practices should be required to renew more frequently. A supplier which has undergone a change In ownership or other significant change should be required to renew more frequently—within a reasonable period of time after the change in ownership.

This approach is consistent with the OIG's recommendations to update provider number records regularly, deactivate provider numbers without current billing history, establish adequate controls to assure suppliers not legally authorized to provide services are Identified and their provider numbers are deactivated, that HCFA evaluate provider number controls as part of its Contractor Performance Evaluation Program, and negotiate with State licensing authorities to obtain license and registration information. (See "Carrier Maintenance of Medicare Provider Numbers," Office of Inspector General OEI–06–89–00870 (May 1991))

(4) *National Administration:* Currently, once a supplier receives a provider number from a carrier, the carrier typically does not have the ability to determine whether that supplier has been subject to a disciplinary action or has been the subject of state or federal disciplinary action, either In that carrier's jurisdiction or nationally. A nationally administered and consistent system would allow HCFA, the OIG and carriers to easily and effectively track supplier billing patterns and history nationally. National administration would ensure beneficiaries that all suppliers adhere to identical basic business standards and are subject to the same level of scrutiny.

The Home Care Coalition also recommends establishing a "hotline" to be part of the nationally administered provider number system for suppliers. A hotline would enable consumers, patients, referral sources, physicians and others to call a central information bank to find suppliers in a certain area, determine whether and if any complaints have been filed against a supplier, and determine other pertinent information about suppliers which the provider system could monitor.

C. Additional Recommendations

To fully realize the benefits of improving the provider number system, there must be some additional changes, as part of the provider number system Improvements.

Carrier Jurisdiction Rules: The carrier jurisdiction rules need to be changed to require claims to be submitted to the carrier with jurisdiction where the patient resides ("zip code jurisdiction"). HCFA is currently implementing such a rule, yet the Secretary should have discretion to create exceptions for reasons that permit administrative efficiency without the opportunity for abuse (e.g., snowbirds).

Specialty Carriers: Congress should require HCFA to consolidate the number of carriers processing home medical and long term care supply claims to no more than five. HCFA is currently Implementing specialty carriers, yet Congress should authorize the Secretary to allow non-insurance companies (e.g. data processing companies) to qualify as a Part B carrier.

National Uniform Coverage and Utilization Parameters: The Home Care Coalition recommends that Congress require HCFA to establish national uniform coverage criteria and utilization guidelines, and to establish a mechanism to annually update and revise such guidelines using an advisory panel that includes consumers and suppliers. HCFA is current Implementing limited regional guidelines behind closed doors—not in an open and public forum with consumers and suppliers' advice.

D. Provider Number Summary

In summary, before a supplier could receive and maintain a Medicare provider number, the supplier would have to meet basic business, health and safety; disclosure and renewal standards and requirements. For example:

1. *Basic Business. Health and Safety Standards*

a. No prior exclusions from Medicare or Medicaid

b. Supplier must maintain physical facility with personnel on-site

c. Supplier must provide proof of product and professional liability insurance

d. Supplier must meet the following requirements:

(i) all suppliers must meet basic business, health and safety standards

(ii) oxygen suppliers must meet more rigorous safety and equipment management standards

(iii) PEN/IV suppliers must meet more rigorous applicable standards

e. Secretary shall grant deemed status for any of d.

f. Successful completion of an on-site inspection to ascertain compliance, resulting In a certificate of compliance

2. *Disclosure Requirements*

a. Physician, hospital, nursing home, home health agency, or other health care entity ownership interests

b. Types of products and services

c. Sales/marketing Information and practices

d. Compliance with state and federal laws and regulations (e.g., FDA, OSHA, DOT, etc.)

3. *Renewal*

a. Periodic renewal

b. More frequently for suppliers with questionable business practices

4. *Administration*

a. National administration

b. Carrier/HCFA capability to renew and verify application information

c. Hotline for consumers, referral sources, physicians, etc. to call for information on suppliers, and for a forum in which to register complaints about suppliers, such as the Better Business Bureau

d. Change carrier jurisdiction rules to zip code billing

e. Specialty carriers for HME and long term care supplies

f. National uniform coverage and utilization parameters for HME and long term care supplies

III. ADMINISTRATIVE EFFICIENCY: CMN REFORM

The costs of health care administration In the United States consume an increasingly large portion of our country's health care spending. One report estimates that physician office overhead costs accounted for 45 percent of physicians' gross Income In the United States (see *"The Hassle Factor: America's Health Care System Strangling in Red Tape,"* American Society of Internal Medicine, 1990). Another report estimates that U.S. physicians' overhead and billing expenses, excluding malpractice premiums, constituted 43.7 percent of their gross professional income (see *"The Deteriorating Administrative Efficiency of the U.S. Health Care System,"* The New England Journal of Medicine, May 2,1991, p. 1253).

The Medicare program is no exception. Recent health care policies have increased the bureaucratic burdens/costs of health care administration. The administrative activities necessary to document care provided to beneficiaries compete with the time available for direct patient care.

One provision of the Omnibus Budget Reconciliation Act of 1990 greatly expands the amount of time a physician must spend to detail the medical equipment requirements of his or her patients. This law, enacted by section 4152(f) of OBRA 1990, requires physicians to complete certificates of medical necessity (CMN) for all items of durable medical equipment (DME). Not only does this impose additional unnecessary administrative burdens on the physician, but the provision is administratively unworkable and unenforceable by HCFA and OIG.

Once a physician determines the medical need for an item of HME, an analysis of patient needs is often conducted by discharge planners, home health agencies and others in consultation with HME suppliers who are more knowledgeable than physicians about the precise technology and type of equipment best needed to meet the patient's specific needs. This information is then provided to a physician, who authorizes its use by completing and signing a CMN. Prior to the OBRA 1990 provision, the supplier would complete the information on the CMN, and forward it to the physician who was still responsible for verifying the information on the CMN and attesting to its accuracy.

As a practical matter, there are currently no incentives, financial or otherwise, for a physician to complete CMNs, nor are there penalties for a physician's failure to comply. Physician failure to comply may ultimately decrease beneficiaries' access to services in a timely fashion.

The correct policy should aim for administrative efficiency while addressing perceived abuses. The correct policy should target abusive suppliers and over utilized items, not penalize physicians, patients, suppliers and discharge planners.

Furthermore, Congress has proposed and HCFA is implementing a number of reforms which will directly address the problems that have encouraged the questionable practices of some suppliers such as direct beneficiary telemarketing and carrier forum shopping. The one remaining necessary reform Is enactment of the supplier number system as described above.

Recommendation:

The Home Care Coalition recommends that section 4152(f) of OBRA 1990 be amended so that it applies only to "abused" or "overutilized" items of home medical equipment. Under current law, the physician must complete the certificate of medical necessity (CMN) for home medical equipment. Suppliers are prohibited from distributing to beneficiaries or physicians completed or partially completed CMNs, for the convenience of the physician, for home medical equipment.

IV. CONCLUSION

The Home Care Coalition urges the Senate Finance Committee to work toward the development of a provider number system as described in this testimony for beneficiaries and the home medical equipment, supplies and services industry.

The Home Care Coalition recommends a new provider number system with the following components:

- basic business, health and safety requirements
- business practice and ownership disclosure
- periodic renewal
- national administration, Including consolidation of carriers, uniform coverage and utilization parameters, and "zip code" billing

By organizing the business relationships between Medicare and suppliers as outlined in this testimony, the Home Care Coalition believes that there will be a marked decrease in the undesirable practices that have caused concern. Medicare beneficiaries must be assured that they will receive HME services only from companies that meet minimal business, health and safety standards. This will result In a more cost effective, efficient and effective program for Medicare beneficiaries, the federal government, suppliers, and the health care system as a whole.

The Home Care Coalition recommends that section 4152(f) of OBRA 1990 be amended so that it applies only to "abused" or "overutilized" items of home medical equipment.

The Home Care Coalition is happy to work with the Committee and its staff in further developing legislation that would accomplish these objectives.

Appendix A.—Home Care Coalition

The mission of the Coalition to Support Quality Home Medical Equipment, Supplies, and Services is to preserve the Medicare durable medical equipment benefit, to support quality home medical equipment, supplies, and services, and to improve access to these services. The primary goals of the Coalition will be those which focus on education and communication directed to its members, policy makers and the public. In meeting its goals, the Coalition will contribute to the well being of home care patients, will advance the concept of home care as a vital component of a cost effective health care delivery system, and will improve access to home care services."

EXCERPTS FROM PATIENT LETTERS

The following excerpts are from letters written by members of Emphysema Anonymous, a consumer support group for patients with emphysema.

"Associated Healthcare of Buffalo has been my oxygen supplier since December 1987. From the start, their [sic] aim has been to make life as comfortable and uncomplicated as possible for me. Everyone, from the telephone receptionist to the delivery person, goes out of his way to help me. I never hesitate to call them because I know I will be helped in a fast and friendly fashion."

VMB, Kenmore, New York

"You can't believe my panic when a rain, wind and thunder storm cut out my electricity leaving me literally breathless.

"My portable tank was only ⅓ full. I called Vital Aire, mind you this was 2 a.m. A neighbor came up and put me on the liquid oxygen and calmed me down. An hour

and ½ later a service man was here and with lots of time to spare I was given 2 new tanks and lots of comfort and understanding. The power came back on and all was better than well. I was only one of five this gentleman had aided this nite [sic].

"For a month the weather remained bad and the power lines got older and Vital Aide and I had much more communication. They equipped me for visits to dentist and doctor with the portable and now because of electricity problems they have given me a huge green tank, portables and care on my elect. oxygen . . .

JBH, Lomita, California

"I have the best medical supplier. Most of the people I know have him as there [sic] supplier. We all think a great deal of him . . . . No matter when you call he always talks to you and answers any questions or gets an answer for you. When you start any medication or medical equipment he makes sure you understand how to use it. He is very pleasant. We usually, pick up my medical supplies at his store. His wife and receptionist are very nice."

LED, Mobile, Alabama

"They come without every being called and change the [nebulizer] filter and make sure it is running correctly."

MED, East Islip, New York

"For the past few months they have had a driver named Bob. He is very sensitive and cooperative and reacts positively to any suggestions I might make."

MJT, Taunton, Massachusetts

"I was instructed and reassured by the kind and considerate staff at the office and at my home, through repeated questions on my part, there was always a polite and understanding answer on theirs [sic]. No matter what the emergency, I have never been without oxygen at any time thanks to an excellent 24 hour a day service department. I am on a liquid oxygen plus portable system, which enables me to leave the house for medical appointments etc. Without this system I would be totally house bound for the rest of my life."

DB, North Babylon, New York

"Michael Limn, BSRT, has been a positive influence in my successful quest for an active life with the assistance of oxygen therapy. CP Homecare without exception has delivered promptly, anything required for my care."

TRS, Newark, Ohio

"They know our finances are very limited so they take what Medicare pays and don't charge me the difference. They come to the house once a week, fill it, and give me whatever hoses I need. What great people!"

GP, Bend, Oregon

"He again took time to explain how it [the oxygen concentrator] works, cleaning the filter, and what to do if the alarm sounds, the [electric] current went off. He is a pleasant and knowledgeable person.

MS, Homosassa, Florida

Appendix B.—The Home Medical Equipment Industry: An Examination of the Industry's Expense Structure

I. BACKGROUND

The home medical equipment industry has experienced a number of changes affecting reimbursement for their services. Most recently, the Administration's fiscal year 1991 budget proposes significant reductions in reimbursement for home medical equipment (HME) by capping payment amounts at the national median of all carrier-based fee schedules. This would prohibit virtually any regional variation in payment which exists under the current fee schedule. This report demonstrates that geographic variation in payments results from characteristics of the HME industry, namely that a substantial portion of the costs associated with home medical equipment services are locally driven.

The HME industry is characterized by many manufacturing companies, which produce the home medical equipment. This equipment is delivered and serviced by many small local providers of care. These local providers ofcare, or dealers, are generally single location owner-operated dealerships.

The majority of the costs for HME are associated with the service component of the products, which is very labor intensive.

The HME dealer not only delivers the equipment necessary to allow someone to be cared for at home; the dealer also is responsible for determining a patient's equipment needs, training the patient or family in the use of this equipment, servicing this equipment through the period of need, and retrieving the item when it is no longer required. Equipment acquisition is only one part of the overall costs to a HME dealer; the majority of the costs for HME are associated with the service component of the products, which is very labor intensive.

In examining the impact of reimbursement changes, it is extremely important to understand the nature of the HME industry. The current method of Medicare reimbursement ("Six Point Plan") for HME has achieved the dual objectives of the industry and the government: to maintain access to quality care with no added burden imposed on beneficiaries while at the same time reducing administrative costs and program outlays. These objectives may not be reached if local differences are not considered in the reimbursement for HME. A national pricing system that standardizes reimbursement amounts may jeopardize the solvency of many HME dealers, resulting in a reduced access to care for Medicare beneficiaries.

II. THE HME INDUSTRY IS A LOCAL, LABOR INTENSIVE SERVICE INDUSTRY

Home medical equipment generally is supplied by local dealers, whose costs are driven by the characteristics of the local community. Local characteristics which strongly influence operating expenses include wage rates, characteristics of the local Medicare carriers as well as other characteristics, such as insurance rates and community characteristics (i.e. urban/rural, etc.).

A. Local Wage Rates

Labor costs (i.e., wages and benefits) represent 60 percent of the total costs of HME and vary significantly across geographic areas. Current local pricing systems, however, implicitly take wage differences into account. Health care is a labor-intensive service industry and HME is no exception. For example, current Medicare payment for inpatient hospital services under the prospective payment system (PPS) makes adjustments for community wage rates, recognizing the importance of labor costs even though PPS is a national system.

Labor costs represent 60 percent of the operating expenses of HME . . . current pricing systems implicitly take wage differences into account.

HME dealer costs are heavily influenced by labor costs. Labor costs associated with providing these services include the costs associated with actually providing the service as well as the costs associated with the administration of the dealership. This can be compared to the importance of labor costs in a hospital; the services are provided by personnel including nurses and allied health professionals but the hospital also depends on administrative personnel to deal with billing and other operational issues.

Labor expenses are a large component of total costs because the activities involved in getting the product to the client are numerous and complex.

Labor expenses are a large component of total costs because the activities involved in getting the product to the client are numerous and complex. According to a recent Ernst and Whinney study, a HME dealer must meet the requirements of:

- **The patient and caregiver**—to ensure the equipment is available when needed, is operational, and that its proper therapeutic use is understood.
- **The medical professional overseeing patient care**—to ensure the prescribed equipment is installed, the proper therapy is administered, and adequate follow-up and monitoring is provided to guarantee continued effectiveness. This process usually includes responding to the referring physician, the hospital discharge planner, and the home health agency providing nursing services.
- **The payer**—to ensure reimbursement is received. Payers require HME dealers to provide proper documentation and to comply with the established internal policies as well as state and federal regulations.[1]

[1] Ernst and Whinney. *From Producer to Patient: Valuing Distribution in the Home Health Care Market* (Washington, DC: Health Industry Distributors Association Educational Foundation, 1987) p. 9.

In addition, the highly-technical nature of the equipment and products supplied by the HME industry requires HME dealers to depend heavily on specially-trained personnel which further increases costs.

Because HME services are labor intensive, the cost of providing these services rises as wages increase. However, from 1983 to 1989, while real wage growth in the United States equaled 2.2 percent per year, or approximately 15.4 percent over the entire period; due to freezes in payments to Part 8 suppliers as well as a number of other changes which affected HME, Medicare-allowed payments for HME received only one increase of 1.7 percent over the same time period.

In order to care for someone in the home, the representative of the HME dealership must take several steps. First, the dealer must work with the patient and physician to select the appropriate equipment. They may also have to coordinate equipment availability with hospital discharge planners. Second, the equipment must be delivered and set up. Third, someone in the home (i.e., either the patient, relative, or friend) must be trained to operate and maintain the equipment, if necessary. Fourth, the equipment must be serviced and supplies must be delivered to the home as required (for example, for someone requiring oxygen, deliveries must be made on a routine basis). In addition to routine servicing, dealers must maintain 24-hour availability of staff to resolve any emergency problems. Finally, at the completion of the contract, the equipment must be picked up and returned to the dealership. All of these activities are highly labor intensive.

> *. . . total administrative costs can represent up to 60 percent of total operating and non-operating expenses.*

Not only is the provision of HME services labor intensive, but labor also is required for the administrative aspects of this service. Administrative requirements may vary by location and payer, but generally include: claim and order processing, obtaining referrals, and billing and collections. A 1987 report by Ernst and Whinney found that, although administrative costs varied depending on the type of medical equipment under consideration, total administrative costs can represent up to 60 percent of total costs,and is likely that these administrative expenses have increased even further since that time.[2]

Most HME dealers accept assignment for Medicare claims and are, therefore responsible for getting the claim paid. All documentation required by the carrier must be prepared by the HME dealer, and this process can take several hours to complete. Furthermore, the HME dealer must engage in billing and collection activities associated with these services since they bill the patient for the remaining 20 percent of the Medicare allowed reimbursement amount. Finally, claim appeals have a large impact on costs since the process greatly increases the need for additional paperwork as well as time to process an appeal. It also influences the age of accounts receivable, which represents a real cost to dealers.

Educating physicians and obtaining referrals is also a labor intensive activity. HME dealers must continually educate their referral sources about the changing regulatory processes related to Medicare and other third-party reimbursement. Maintaining communication between dealers and physicians and other referral sources not only serves the beneficiaries, but enables HME dealers to preserve a stable volume of clients and allows dealers to devote more time and resources to physical distribution and servicing of equipment.

B. Local Carrier/State Requirements

HME dealership costs also depend on other community characteristics including the characteristics of the local carrier. Some carriers may require more or different documentation than others. In addition, some carriers are more efficient at claims processing. Medicare regulations stipulate that carriers must reimburse 95 percent of "clean" claims (i.e., claims that are complete and accurate) within 24 days of receipt. Carriers have an additional 60 days to process rejected claims, which in many cases may mean that the entire documentation process must be repeated. According to a recent HCFA report, which tracks Medicare carrier performance in meeting the prompt-payment requirements for HME claims, only about one-half of all carriers met these requirements in January, 1990.[3]

In addition to carrier variations, local dealerships must meet any state requirements for provision of these services. Some states require that suppliers employ credential medical professionals in order to be licensed in the state. For example, the State of California requires a physician medical director and registered respiratory

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[2] Ernst and Whinney, 1987, pp. 19-20.

[3] HCFA Monthly Claims Processing and Timeliness Report, January, 1990.

therapists to be on-staff as part of state licensure requirements. Finally, local hearth maintenance organizations (HMOs) and the Veteran's Administration require clinical supervision in the use of some HME products. Such state/payer requirements can increase dealership charges for the services they provide and cause additional variation in charge patterns across states.

C. Other Characteristics

Finally, a local dealer's expenses depend upon community characteristics such as whether their community is largely urban or rural, whether the population is geographically dispersed, and the extent of local traffic congestion. Expenses also depend upon the characteristics of the particular dealership, such as the mix of services provided, and on factors related to local insurance rates (e.g., workman's compensation and vehicle insurance).

If a HME dealer's product mix is heavily reliant on products which require frequent maintenance or patient training, and therefore, several visits to the patient's home are required, then the cost of providing services depends on the cost of gasoline and the time and distance to the patient's home. In areas where there is severe local traffic congestion or in rural areas where the distance to the patient's home is far, operating expenses will be higher.

Insurance rates can vary widely from state-to-state and can also vary by local community. Workmen's compensation and vehicle insurance rates, for example, range from $1.59 per $100 to $8.13 per $100 and $83 per month to $280 per month, respectively, according to a survey of national HME companies.

III. GOVERNMENTAL COMPLIANCE COSTS

The cost of complying with government regulations can be exceedingly high for HME dealers.

The cost of complying with government regulations can be exceedingly high for HME businesses. While federalregulations are standard and affect dealers uniformly, stateand local regulations may not. Federal regulations are those related to Medicare, the Food and Drug Administration (requirements regarding transportation and delivery of oxygen), Department of Transportation (regulations regarding HME delivery vehicles), and OSHA and EPA, and employer-paid mandated employee benefits (e.g., unemployment compensation). Regulations which vary from state to state or locality to locality include Medicaid regulations', state and local sales tax and individual state licensure.[4] For example, state sales tax, which is payable on Medicare charges but is not reimbursable from Medicare or from the patient, ranges from one percent in Colorado to seven percent in Washington. As discussed above, certain state licensure regulations (e.g., California) require on-staff physician medical directors and respiratory therapists; however, these clinical expenses are not reimbursable by Medicare. In addition, private accreditation to ensure high quality of care is widely embraced voluntarily by the industry, which both improves quality and relieves the government of quality assurance costs.

In addition, several HME items which are reimbursable under Medicare (e.g., oxygen) require physician completion of certificates of medical necessity (CMNs) in order to document the patient's medical need for the HME item. The process of certification and recertification can be complex and costly. Thus, HME dealers with product lines heavily comprised of such items will experience much greater administrative costs than dealers with a different product mix.

IV. IMPACT OF HME PRODUCTS AND SERVICES ON BENEFICIARY QUALITY OF LIFE AND COST OF CARE

Frequently, care of the patient at home is a substitute for more expensive institutional care.

Several recent studies have shown that the care needs of patients in nursing homes and home health care have increased since the adoption of the prospectivepayment system for hospitals (DRGs). This trend emphasizes the importance of HME products and services as a vital component in the continuum of care. A typical pattern of home care delivery is characterized by home hearth care workers who provide skilled and personal care and HME suppliers who provide various types of equipment and services including oxygen, life support respiratory devices, intravenous therapy, and home medical equipment, such as hospital beds and

[4] In addition, at least one state (Alabama) imposes a rental tax on dealers; rental taxes may also exist at the local level.

wheelchairs. Frequently, care of the patient at home is a substitute for more expensive institutional care either in or hospital or nursing home.

As discussed above, the HME supplier not only provides equipment to the patient, but HME personnel also interact with physicians and home care professionals to ensure that the patient's quality of life and quality of care are enhanced. They interact with these professionals to establish the patient care plan, provide education to home health care workers, patients, and patients' families regarding the use of home medical equipment. Finally, they monitor patient's progress throughout their dependence on the equipment.

Other quality issues expected of HME suppliers include timely delivery of equipment and availability of services seven days a week, 24 hours a day. In addition, as the American Association of Continuity of Care pointed out before the Subcommittee on Health of the House Ways and Means Committee, "patients who live in rural areas as well as inner city 'high risk' areas are expected to be provided the same level of service as those patients living in conveniently located areas." For many patients, the HME supplier is the sole provider of in-home services due to stringent eligibility requirements for the Medicare home hearth care benefit. It is clear that if HME suppliers were not able to provide the required level of service, the patient could not be cared for at home. In addition to the cost savings frequently associated with home care, the patient usually prefers to be cared for at home, and several studies demonstrate improved recovery in the home setting.

Low oxygen reimbursement amounts under the Medicare "Six Point Plan" already have limited beneficiary access to oxygen services in some areas of the country. For example, national HME dealers have closed branches in states with low reimbursement rates and discontinued service in some rural communities. The Mayo Clinic, for example, has reported that it can no longer discharge oxygen and ventilator-dependent patients to their homes because HME suppliers can no longer afford to serve these patients. As a result, these patients must remain in acute-care settings, which are significantly more expensive than being cared for in their homes.

V. CONCLUSIONS

If access to care is to be assured, it is critical that reimbursement consider these local differences.

This information provides evidence that the cost of services provided by local HME dealerships depends uponmany local factors. The most important of these factors isthe cost of labor. If access to care is to be assured, it is critical that reimbursement consider these local differences. The Six Point Plan, while it significantly reduces large payment variation, continues to allow regional variation. The Administration's proposed budget for FY 1991, however, would require a fee schedule based upon national median charges. This plan, if enacted, will result in severe reductions in payments for particular items of HME in many geographical areas.[5] Information on the characteristics of the industry suggest that, while national limits on payment may be appropriate, local and regional differences must be considered.

Attachment.

Economic Analysis of Home Medical Equipment Services

[Prepared for: Health Industry Distributors Association, Health Industry Manufacturers Association, and the National Association of Medical Equipment Suppliers]

The analyses completed for these diagnoses find that using home care in combination with inpatient treatment less costly in all cases than simply using inpatient treatment. When the cost-benefit analysis includes a quality of life factor, combination inpatient/home therapy has even greater savings. Potential savings of between $300 and $2,330 per patient episode have been identified (see Table A). As seen in the table, the resorting annual savings range from $500,000 to $575 million.

Table A.—THE COST EFFECTIVENESS OF HOME CARE SAVINGS TO SOCIETY PER QUALITY ADJUSTED EPISODE

Type of Patient	Savings per Episode	Prevalence	Annual Savings
Hip Fracture	$2,300	250,000/year	$575,000,000

[5] For further analysis of this issue, see Lewin/ICF, *Analysis of the Impact of Reimbursement Changes on the Home Medical Equipment Industry,* July 26, 1990.

Table A.—THE COST EFFECTIVENESS OF HOME CARE SAVINGS TO SOCIETY PER QUALITY ADJUSTED EPISODE—Continued

Type of Patient	Savings per Episode	Prevalence	Annual Savings
ALS with Pneumonia	300	1,533/year	459,900
COPD	520	93,184/year	48,455,680

Source: Lewin/ICF analysis.

The pressure on the providers to reduce length of inpatient stay as well as the development of locally.managed home medical equipment services that allow for more care in the home are largely responsible for these savings. Physicians are increasingly aware of the availability of home medical equipment and home hearth care services and factor these choices into their practice decisions. Full realization of the potential of home health care services and home medical equipment services can achieve significant cost savings as well as improve patient satisfaction.

I. INTRODUCTION

The literature on economic analyses of therapeutic interventions includes two categories of articles: those that consider only costs (cost-identification analyses) and those that consider both cost and clinical effectiveness ("cost-effectiveness analyses"). Cost-identification analysis attempts to identify all of the costs associated with a particular therapy. This information can then be used to determine the least costly intervention. In the case of home IV treatment of osteomyelitis, for example. many articles compare inpatient to outpatient costs In order to determine the least expensive treatment setting. These studies may not consider the clinical effectiveness of alternative settings.

In order to estimate cost versus effect, a "cost-effectiveness study must be initiated. While there are several types of "cost-effectiveness" analyses, the most relevant technique for comparing treatments where no change in life expectancy is anticipated, is the cost-benefit analysis A cost-benefit analysis compares the costs and benefits of treatment alternatives by placing the costs and benefits in the same units (usually dollars). For example, a decrease in quality of life associated with inpatient treatment in a hospital setting could be quantified and considered in a cost-benefit analysis.

There has been a great deal of discussion surrounding the importance of treatment setting. With the advent of the Medicare prospective payment system (PPS), other cost containment policies, and the development of new technologies which allow more diseases to be treated in the home setting, more and more patients are being cared for entirely, or in part, in the home. Home medical equipment (HME) services have become more sophisticated and more widely available, and this has clearly been a driving factor behind the reduction in inpatient hospital days. There has been, however, no attempt to systematically identify the resulting cost savings from home care. In addition, most people prefer care in the home to care in an institutional setting, and this, therefore, is an additional benefit of home care.

Lewin/ICF conducted a search of the clinical economic literature identifying available articles examining the cost-effectiveness of treatment in the home setting. Most studies conducted to date have not quantified differences in effectiveness. They either assume equivalent effectiveness between treatment settings or contain no mention of effectiveness.

A two-part analysis was completed: a cost-identification similar to those appearing in the literature and a cost-benefit analysis which compares identified costs to benefits, which includes a quality of life factor. As has been done in many previous studies, the analysis presented in the following sections assumes equal effectiveness between treatment groups. Data presented in a recent JAMA article comparing pre- and post-PPS data support this assumption of equivalent effectiveness.[1] The article reports no significant increase in deaths or rehospitalization rates within 180 days for five major diseases including hip fractures and pneumonia.

There are several ways in which the analysis here improves upon the existing cost-effectiveness literature for home therapy. First, we will compare length of stay between treatment settings and compute additional costs due to an increase in treatment days; many studies identified so far have not done this. Second, our section on cost of home equipment and supplies should be superior to any similar section found in the literature to date.[2] Third, our study incorporates quality of life, which has not been done in any of the studies identified in the literature although it has been clearly recognized as a benefit of home care. Analysis of specific patient

episodes including hip fracture, ALS with pneumonia, and COPD follows a general discussion of economic evaluations.

II. OVERVIEW OF GENERAL METHODS FOR ECONOMIC EVALUATIONS

A. Perspective

When designing a cost analysis, it is important to determine the perspective of the study. The analysis can be considered from an individual's perspective, from a provider's perspective, from a payor's perspective (such as HCFA), or from the perspective of society as a whole. Many times, the results of an economic analysis will differ depending on the perspective of the analysis. A brief description of each perspective follows with the hypothesized results.

1. Individual

From the individual's perspective, due to health insurance coverage patterns, inpatient care is generally less costly than care in the home setting. In the home setting the individual incurs additional costs: higher co-payments for outpatient medical care, non-medical costs (e.g., transportation, housekeeping, etc.), and equipment and supply costs not covered by insurance either public or private. Most of these costs would be covered by the patient's acute-care insurance in the inpatient setting. If an individual prefers to recover in a home setting, quality of life considerations may shift the results of the analysis in favor of home therapy. Quality of life, however, is difficult to quantify and usually is regarded as a subjective measure.

2. Provider (Hospital and Physician)

The Medicare Prospective Payment (PPS) system provides incentives to minimize length of stay since payment does not depend on time in the hospital. In the outpatient setting, the physician receives additional reimbursement for subsequent physician visits and the hospital may be reimbursed for additional outpatient laboratory tests, outpatient services, and emergency room use. Thus, the results of a cost-effectiveness study from the hospital's and, possibly the physician's, perspective are likely be in favor of home therapy.

3. Third-Party Payers

The, results of a cost-effectiveness study from the insurer's perspective would likely be against home therapy for the same reasons that the provider's would be in favor of treatment in an outpatient setting. In a combination of inpatient and outpatient treatment settings, the insurer would reimburse the provider for hospital care, subsequent physician visits, laboratory tests, and emergency room use. In addition, they may reimburse for some home nursing care costs and home medical equipment, supply and service costs. In the case of Medicare, expenditures for treatment in the inpatient setting include only the lump-sum DRG payment which does not depend on length of stay.[3] If outlier expenditures are avoided by discharge to home care, the predicted result of the cost-benefit analysis could change, and home therapy may be less expensive. Over time, however, even under the Medicare system, if patients are treated at lower cost, the relative weight for the DRG will be reduced, resulting in program savings in the long-run.

4. Society

When an analysis is conducted from the viewpoint of society as a whole it examines the use of health care and other resources regardless of who is paying for them. Most of the articles identified in the literature search contain analyses from this perspective. These studies usually find that a combination of inpatient care and home care uses fewer total health care resources than recovery only in an inpatient setting if home care can significantly reduce inpatient costs.

After considering the perspectives listed above, Lewin/ICF chose to analyze the total costs and benefits of home therapy to society.

B. General Methods for Calculation of Costs

Costs are probably the best defined characteristic appearing in the clinical economic literature. The type of costs considered are direct costs (medical expenses such as hospital, physician, laboratory, and home medical equipment) and indirect costs (treatment induced loss of productivity and wages). Strategies for calculation of costs for the two treatment methods are detailed below.

1. Inpatient Treatment

- **Inpatient Costs**—Hospital *charges* are readily available, but costs are more difficult to estimate. Many studies have used payment under the Medicare DRG system as a proxy for hospital costs. Other inpatient costs include physician reimbursement, where Medicare allowable charges for physician services can be

used to quantify physician costs. In this analysis, hospital payments under the Medicare DRG system were used as a proxy for inpatient costs since the data are readily available and current DRG payment weights are updated annually by using actual charge data. Use of Medicare payment amounts also allows us to incorporate changes in resource use over time by using the DRG relative weights to estimate costs. For example, the 1984 weight for a particular ORG reflects normal practice at that time, prior to the availability of many types of home medical equipment services. The 1990 weight incorporates changes in resource use associated with the availability of these services. Therefore, in calculating inpatient costs we applied the 1984 DRG weight to the 1990 standardized payment amount to calculate hospital costs when stays were longer. The 1990 weight, along with the 1990 payment amount was used to represent the resource costs associated with the shorter inpatient stay.

• **Non-medical Costs**—While in the hospital a patient may incur non- medical home costs, for example, housekeeping and child care costs.

• **Indirect Expenses**—Work days and subsequent income lost due to illness are among the most frequently considered indirect costs. For non-working patients, indirect expenses are considered to be the costs associated with an individual's inability to perform his or her usual activities. Both of these indirect expenses can be combined into a single measure such as bed disability days. For the purposes of our analysis, the cost of a bed disability day is assumed to be the minimum hourly wage.

2. Home Care

• **Inpatient Costs**—Patients to be examined in this study are initially admitted to the hospital and subsequently released to continue therapy in the home setting. Thus, these patients will also incur some portion of the inpatient costs discussed above. The costs are estimated by dividing the total inpatient costs by the average length of stay. Costs are then adjusted to reflect an increase in use of hospital resources during the initial days of treatment. For example, Eisenberg and Kits,[4] completing a cost-effectiveness analysis of home IV therapy, multiply the inpatient per diem amount by 1.25 to reflect a 25 percent increase in resource use during the initial days of treatment.

• **Outpatient Hospital and Physician costs**—Over the course of outpatient therapy, the patient may require visits to the physician, outpatient department, the emergency room, and possibly laboratory costs.

• **Personnel**—This category includes expenditures on home nursing care or personal care. In addition, frequently these personnel provide necessary training to families so that they can provide required care.

• **Home Medical Equipment Supplies and Services**—This includes the cost of all equipment and supplies required for home care as well as the cost for set-up, delivery and training of family members in the use of the equipment.[5]

• **Indirect Expenses**—These costs are identical to those discussed in the inpatient treatment section above.

C. Benefits

While costs tend to be well defined in the clinical evaluation literature, benefits are generally not considered. The cost-benefit analysis portion of our study will include the evaluation of the major benefit of home care, namely improvements in quality of life resulting from the patient being cared for in the home. Unfortunately, changes in quality of life are difficult to quantify in economic terms. In this analysis, we propose to adjust the inpatient treatment days (i.e., increase the total days of the stay) to reflect a *decrease* in quality of life resulting from the hospital stay. The number of total quality-adjusted treatment days could then be multiplied by the average daily inpatient cost as a method of incorporating quality of life into the model. While there are clearly many additional benefits in terms of quality of life, we were limited in our analysis to those which could be quantified.

In order to define the decrease in quality of life attributable to inpatient hospital stay, the literature in this area was reviewed. Of all of the evaluations identified, the Quality of Well Being Scale developed by Dr. Robert Kaplan[6] was most suited to our analysis due to its reproducibility, community-wide rather than population-specific basis, and broad acceptance in the literature. The Quality of Well Being Scale assigns a weight to various health states represented by descriptions of functional impairments and symptoms. The functional impairment component is divided into three scales representing different aspects of daily functioning—mobility, physical activity, and social activity—whereas the symptoms component is comprised of a list of symptomatic complaints that might impair quality of life.

Our analysis, a comparison of inpatient and outpatient treatment strategies, concerns only the functional impairment component of the scale; patient symptoms do not change with treatment setting. Two studies quantifying the Quality of Well Being Scale were used in our study to adjust for quality, one by Dr. Robert Kaplan (Kaplan) and a second completed by the Oregon Health Services Commission[7] (Oregon). Table 1 lists the levels of the functional component and the weights associated with the two studies. In our analysis, we have assumed that two factors, hospital or nursing home (mobility) and limitations in role activity (social activity) describe the quality of life differences between the hospital and home treatment setting. As shown in Table 1, for example, according to these studies a day spent in the hospital or nursing home is valued at 6.3 percent less than a day of complete mobility.

In our analysis we have assumed that all patients, regardless of treatment setting, would be unable to drive a car or use public transportation, would not be able to engage in significant physical activities, and would need help using the bathroom and eating. The only differences in quality of life, therefore, relate to being in the hospital/nursing home (–6.31/–9.0 percent) and with being able to assume their role activity (–6.3/–6.1 percent). Therefore, we estimate that the decrease in quality of life associated with inpatient hospital stay varies between 12.6% in the Oregon scale and 15.1% in the Kaplan scale. Our analysis adjusts the number of inpatient treatment days to reflect the mean decrease, 13.85% (12.6 + 15.1 + 2). and recalculates the costs associated with inpatient treatment. Thus, one inpatient day is adjusted to 1.1385 inpatient days and costs are recomputed using the number of adjusted treatment days.

Table 1.—QUALITY OF LIFE ADJUSTMENT FACTORS

Major complaint	Oregon weight	Kaplan weight
Mobility:		
Hospital or nursing home	–.063	–.090
Unable to drive a car or use public transportation	–.053	–.062
Physical activity:		
In bed most of day or in wheelchair not under individual's control	–.597	–.060
In bed or wheelchair but could control	–.396	.077
Social activity:		
Need help eating and using bathroom	–.108	–.106
Limited in role activity	–.063	–.061

Source: Lewin/ICF analysis of the literature.

D. Time Frame

The time frame to be evaluated in this study will differ by patient diagnosis. Most studies will examine only the acute portion of the episode (i.e. the initial hospitalization and immediate post-hospital care) although some of the disease categories considered are chronic conditions.

E. Patient Population

This study is conducted from the perspective of society as a whole; therefore, costs are considered which do not vary by payor. Setting aside payor considerations allows the analysis to incorporate any type of patient regardless of insurance coverage (i.e. Blue Cross managed care, or Medicare).

III. ECONOMIC EVALUATION OF HOME CARE

Our analysis comparing hospital to home therapy will focus on three types of patient diagnoses where availability of home medical equipment services has dramatically improved our ability to care for people in the home. These include:

- Hip Fracture
- Amyotrophic Lateral Sclerosis (ALS) with pneumonia
- Chronic Obstructive Pulmonary Disease (COPD)

A. Hip Fractures

It is estimated that the United States spends over a billion dollars annually on 250,000 hip fractures.[8] The high occurrence rate and cost associated with this condition suggest the need for an economic evaluation of alternative treatment strategies. Two main treatment Strategies are evaluated in this analysis:

• Strategy 1: Inpatient treatment for hip fracture with home care for recovery (inpatient)—This treatment course provides 15.9 days of care in the hospital followed by 9 weeks (63 days) of home care.[9] It is assumed that 27.3 percent of patients require home medical equipment services during home care.[10]
• Strategy 2: Shorter inpatient stay combined with more intensive home care for recovery—Length of *inpatient* stay for this treatment strategy is assumed to be 10.1 days,[11] followed by 68.8 days (9 weeks plus 5.8 days) of home and outpatient treatment with 35%[9] of the patients requiring home medical equipment services.

This analysis examines the differences in cost and effectiveness associated with these two strategies. It should be noted that our analysis focuses on differences in the cost of the two treatments; where costs are identical we make no attempt to quantify them.

A large majority of hip fractures occur in the elderly; thus where actual cost data were unavailable,. Medicare reimbursement rates were used as a proxy for costs. Costs considered include direct (medical expenses such as hospital, physician, and laboratory) and indirect (treatment induced loss of productivity and wages) costs. Because a hip fracture is usually treated in a discrete time period, lifetime costs are not considered. Rather, the analysis examines costs associated with: (1) the initial hospitalization; and (2) home care for the remainder of the episode. Cost strategies for the two treatment methods are detailed below. Non-medical costs such as housekeeping, child care, and transportation are assumed to be the same for both treatment strategies and are not quantified in the analysis.

1. Calculation of Costs

a. Inpatient Treatment

• **Hospital Inpatient Costs**—Medicare DRGs are used to estimate hospital costs. In FY 1984, DRG 211 had a weight of 1.9350, corresponding to a payment of **$6,500.21** in 1990 to the average urban hospital in cities with less than one million population, excluding pass-through costs (medical education and capital).
• **Physician Inpatient Costs**—Physician costs for inpatient treatment are similar to physician costs for the combination treatment with the only difference being that the physician will be required to visit the patient once for each of the additional 5.8 days the patient is hospitalized. In 1988, CPT4 code 90260 (Subsequent Hospital Care Each Day, Intermediate Services) corresponded to a Medicare allowable charge of $30.40 ($35.85 in 1990 dollars). Therefore the additional physician costs attributed to the increase in inpatient length of stay totaled **$207.93** (35.85 * 5.8).

b. Inpatient in Home Treatment

• **Inpatient Costs**—The daily inpatient cost is derived by dividing the total DRG payment by the average length of stay. To compute the costs incurred during the inpatient portion of the combination treatment program, we multiply the daily cost by the number of required inpatient days, adjusted to account for an increase in use of hospital resources during the initial days of an inpatient stay. Fitzgerald et al.[12] report that there are more sessions of physical therapy given per post-operative day in the post-PPS data than in the pre-PPS data. Applying the proportions reported in his article to our length of stay data results in 14.1 adjusted inpatient days. Thus, the total inpatient cost incurred during combination therapy amounts **$4,383.83.**[13]
• **Physician Inpatient Costs**—Costs associated with physician care during the initial hospital days are incurred under both strategies and do not need to be considered.
• **Outpatient Hospital and Physician Costs**—Average per patient costs incurred during outpatient therapy as reported by Grazier et. al[9] are shown in Table 2. These measures are derived by dividing total expenditures in these areas for hip fractures by the incidence of hip fractures. Length of therapy for the inpatient strategy is assumed to be 9 weeks, while patients undergoing combination therapy incur an additional 5.8 days of services at a cost of $32.69 or **$93.49** in 1990 dollars.

Table 2.—EXPENDITURES PER HIP FRACTURE

[In 1977 dollars]

Outpatient and emergency room institutional services	$22.00
Outpatient diagnostic and therapeutic services	214.35
Physician office, outpatient, and emergency room	88.87
Drugs (Prescription in a physician setting)	29.91
Total	$355.13

Source: Grazier LK, Holbrook TL, and Kelsey JL: The Frequency of Occurrence, Impact, and Costs of Musculoskeletal Conditions in the United States, American Academy of Orthopaedic Surgeons, 1984.

• **Home Health Agency Personnel**—A recent paper[14] reports home health utilization by Medicare patients for specific diagnoses. The number of home health visits to hip fracture patients and the cost of a home health visit are provided in Table 3. Estimates of per vicit charges are based on 1987 allowed charges inflated to 1990 dollars at a rate of 5.5% per year.[15] Length of therapy for the inpatient strategy is assumed to be 9 weeks, while patients receiving inpatient and home therapy incur an additional 5.8 days of services at a charge of $194.79. When 85% of charges are used as a proxy for costs, the total cost attributable to combination therapy is **$165.57** (2,115.77 ÷ 63 * 5.8 * 0.85).

Table 3.—HOME HEALTH AGENCY VISITS PER PATIENT EPISODE

	Visits	Charge/Visit	Total charge
Skilled nursing	8.56	$74	$633.44
Home health aide	7.63	55	419.65
Physical therapy	12.83	75	962.25
Occup/speech/social work	1.21	83	100.43
Total			$2,115.77

Source: Branch L, Goldberg H, Cheh V et al: Medicare Home Health Clients: Who Are They and What Services Do They Receive During an Episode of Care? Submitted to the *Health Care Financing Review*, April 1990.

• **Home Medical Equipment, Supplies, and Services**—In 1981 (pre-PPS) 27.3% of the patients discharged from the hospital needed home medical equipment (HME). By 1986 (post-PPS) the percentage had increased to 35.0%.[9] Assuming that the 7.7 percentage point increase in the number of HME users is due to early discharge from the hospital (i.e. inpatient and home therapy) the additional cost of HME for the inpatient/home therapy is 0.077 * cost of HME plus an additional 5.8 days of equipment use for all patients needing equipment because of early discharge. As can be seen in Table 4, the average cost of HME is $450.12.[16] This corresponds to an additional equipment and supplies expense attributable to combination therapy of **$49.16** ((.35 * 450.12 –63 * 5.8) + .077 * 450.12).

Table 4.—HOME MEDICAL EQUIPMENT, SUPPLIES AND SERVICES PER EPISODE, 1990

Home Medical Equipment	Rental/Purchase	Fee/Price (9 weeks)	Source
Hospital bed, manual	Rental	$192.53	Sample of Medicare Fee Schedules
Walker—wheeled	Rental	49.77	Sample of Medicare Fee Schedules
Drop arm commode	Rental	67.84	Sample of Medicare Fee Schedules
Toilet safety rails	Purchase	41.40	85% of Price
Transfer bath bench	Purchase	98.58	85% of Price
Total cost (9 weeks)		450.12	

2. Results

The results of our analysis indicate that the move towards reduced inpatient stay along with home care has saved society approximately $2,000 per episode in health care resources (Table 5). The savings are even larger when quality of life is factored into the analysis. Adjusting the number of inpatient treatment days to reflect the

mean decrease, 3.85%, and recalculating the costs associated with inpatient treatment, results in a savings of $2,300 per episode. Thus, treatment of hip fractures by combination therapy is both cheaper and more cost effective than inpatient therapy. In fact, the United States could save approximately $575 million if all 250,000 annual hip fractures were treated using a longer period of home care.

B. ALS with Pneumonia

Approximately 4,600 Americans develop Amyotrophic Lateral Sclerosis (ALS) each year. ALS, also known as Lou Gehrig's disease, is a degenerative disease that is usually diagnosed around age 56. The disease paralyzes voluntary muscles, but leaves people alert and able to think clearly. Eventually, muscles associated with breathing begin to weaken and patients are susceptible to life threatening infections such as pneumonia. Once diagnosed as having ALS, the mean survival rate is three years. At some point during those three years, ALS patients will require home medical equipment services for the rest of their lives.

The degenerative nature of ALS results in a strong preference towards treatment in the home setting. This preference for home treatment suggests a need for a cost-effectiveness study comparing inpatient and home therapy for the treatment of ALS induced conditions such as pneumonia. The two main treatment methods compared in this analysis are:

Table 5.—COST COMPARISON OF INPATIENT AND INPATIENT/HOME TREATMENT OF HIP FRACTURES

Cost Component	Inpatient treatment strategy 1	Inpatient/Home treatment strategy 2
Hospital Inpatient costs	$6,500.21	$4,383.83
Physician Inpatient Costs	+$207.93	none
Outpatient hospital and physician costs	none	+$93.49
Personnel	none	+$165.57
Home medical equipment, supplies, and services	none	+$49.16
Total	6,708.14	4,692.05
Quality of Life Adjustment	+321.79	none
Adjusted total	7,029.93	4,692.05

Inpatient/Home treatment saves $2,016.19 per episode.
Inpatient/Home treatment saves $2,337.88 per quality-adjusted episode.

Notes:
A plus value in one column reflects an incremental cost.
Total costs are used for comparison only and do not reflect total cost of an episode

- **Strategy 1: Inpatient treatment for ALS-related pneumonia**—The patient requires inpatient treatment for 8.5 days and is then released to the home setting for follow-up treatment. All ALS patients require home medical equipment upon discharge.
- **Strategy 2: Shorter inpatient stay combined with more intensive home therapy**—The patient receives only 7.2 days of inpatient therapy and substitutes the additional 1.3 days of inpatient therapy seen in Strategy 1 for 1.3 days of care in the home using medical equipment for support.

Costs considered in our analysis are direct (medical expenses such as hospital, physician, and laboratory) costs. Indirect costs, such as treatment-induced loss of productivity and wages, are considered to be equivalent between settings due to the debilitating nature of the disease. Because ALS varies widely in severity and duration of illness, a discrete episode of pneumonia is analyzed as the time frame and lifetime costs are not considered. Non-medical costs such as housekeeping, child care, and transportation are assumed to be equal between both treatment strategies and are not quantified in the analysis.

1. Calculation of Costs

a. Inpatient Treatment

- **Hospital Inpatient Costs**—Medicare DRGs are used to calculate this amount. In FY 1990, DRG 89 (Simple Pneumonia + Pleurisy Age > 17 w/ cc) had a weight of 1.1029, corresponding to a payment of **$3,704.92** to the average other urban hospital.
- **Physician Inpatient Costs**—Physician costs for inpatient treatment are similar to physician costs for inpatient/home treatment. The difference is only

the additional hospital stay associated with inpatient treatment. Thus, the initial expenditures will cancel out and the only relevant physician costs are visits during additional hospital days. We are assuming one physician visit per day. In 1988, CPT4 code 90260 corresponded to an allowable charge of $30.40 or $35.85 in 1990 dollars. The 1.3 day increase in inpatient stay corresponds to an extra 1.3 physician visits at a cost of **$46.61.**

b. Inpatient/Home Treatment

• **Inpatient Costs**—The hospital portion of the inpatient daily cost is derived by dividing the total DRG payment by the length of stay. To compute the inpatient costs incurred during the inpatient portion of an inpatient/home treatment program, we multiply the daily cost by the number of inpatient days. The average cost per inpatient stay is ($4,040.96÷8.5) * 7.2 = **$3,422.93.**

• **Physician Inpatient Costs**—Cancels out with physician visits described in the inpatient section.

• **Hospital and Physician Costs**—A recent study indicates that clinic visits and ER visits have not demonstrated a significant change between pre-PPS and post-PPS.[9]

• **Home Health Agency Personnel**—An Abt Study reports home health usage by patient diagnosis. The number of home health visits to patients and the cost of a home health visit are provided in Table 6. Estimates of charges per visit are based on 1987 charges inflated to 1990 dollars at a rate of 5.5% per year.[14] The additional charge for home health visits totals $33.93 (See Table 6). When 85% of charges is used as a proxy for costs, the total cost attributable to inpatient/home therapy is **$28.84.**

• **Home Medical Equipment, Supplies, and Services**—It is assumed that all ALS patients will require home medical equipment services upon discharge from the hospital. It is further assumed that inpatient/home treatment will require an additional 1.3 days of home medical equipment costs. To obtain cost/month, purchase prices were reduced by 15% and distributed over an 18 month period.

Table 6.—HOME HEALTH AGENCY VISITS FOR PNEUMONIA PATIENTS PER EPISODE

Type of home visit	Pre-PPS visits	Post-PPS visits
Skilled Nursing	0.160	0.455
Home Health Aide	0.068	0.288

Source: Abt Associates Inc.: Episodes of Hospitalization and PPS—Working Paper, September 21, 1988.

Table 7 displays the monthly cost associated with home medical equipment, supplies and services, $940.88. The cost associated with 1.3 days of equipment is **$40.21.**

Table 7.—HOME MEDICAL EQUIPMENT, SUPPLIES AND SERVICES USED BY ALS PATIENTS

[In 1990 dollars]

Home medical equipment	Cost/month	Source
Oxygen—Portable	$322.84	Sample of Medicare Fee Schedules
Oxygen—Stationary	275.51	Sample of Medicare Fee Schedules
Hospital Bed—Electric	195.73	Sample of Medicare Fee Schedules
Bed Trapeze	40.57	Sample of Medicare Fee Schedules
Walker	22.12	Sample of Medicare Fee Schedules
Bedside Commode	30.15	Sample of Medicare Fee Schedules
Flotation Mattress	46.18	Sample of Medicare Fee Schedules
Toilet Safety Rails	2.30	85% of Purchase Price /18 months
Bathtub/Shower Chair	5.48	85% of Purchase Price /18 months
Total Costs per month	940.88	

Source: Lewin/ICF.

2. Results

The results of the cost-identification analysis, detailed in Table 8, indicate that treatment of ALS patients with pneumonia in an outpatient setting saves approximately $260 in health care resources. When quality of life is factored into the analysis, the cost savings attributed to combination therapy increases to $300. Thus, combination treatment of pneumonia is both cheaper and more cost-effective than inpatient treatment. Assuming that one-third of all ALS patients, 1,533, require treatment for pneumonia each year, society could save approximately $460,000 by choosing a treatment strategy that includes more intensive home therapy with a shorter inpatient stay.

Table 8.—COST COMPARISON OF TREATMENT OF PNEUMONIA IN ALS PATIENTS

Cost Component	Inpatient treatment strategy 1	Inpatient/Home treatment strategy 2
Hospital inpatient costs	$3,704.85	$3,422.93
Physician inpatient costs	+46.41	none
Personnel	none	+28.84
Home medical equipment, supplies and services	none	+40.21
Total	3,751.26	3,491.98
Quality of life adjustment	+45.50	none
Adjusted total	3,796.76	3,491.98

Inpatient/Home treatment saves $259.28 per episode.
Inpatient/Home treatment saves $304.78 per quality-adjusted episode.

Notes:
A plus value in one column reflects an incremental cost.
Total costs are used for comparison only and do not reflect total cost of an episode.

C. Chronic Obstructive Pulmonary Disease (COPD)

In 1988, the National Health Interview Survey estimated the prevalence of COPD to be 13.8 million cases, a 71% increase from 1970 estimates.[17] Chronic obstructive pulmonary disease (COPD) is a term relating to respiratory illnesses involving restriction in breathing capabilities such as chronic asthma, bronchitis, chronic airflow limitation, and emphysema. Because of the wide range of conditions associated with this disease, we have chosen to limit our analysis to a patient facing a long-term prognosis of COPD. Medical management of the condition includes the use of oxygen therapy for a large portion of the course of the disease. COPD patients usually experience negative changes in mood and social behavior as the disease progresses.

The development of equipment to provide home oxygen therapy has aided in the alleviation of some of the depression associated with COPD. In fact, use of home oxygen therapy. and treatment of these patients in the home has become the general practice in care for COPD patients. COPD patients are now hospitalized only for acute flare-up of the chronic condition. They are, however, also spending less time in the hospital even for these acute episodes. This analysis examines the cost-effectiveness of earlier release from the hospital by examining savings resulting for early hospital release, rather than a strict comparison of inpatient and inpatient/home therapy. The treatment strategies compared in the analysis are:

- **Strategy 1: Inpatient treatment for COPD**—The patient requires inpatient treatment for 7.5 days and is then released to the home setting for follow-up treatment. All Patients will require home medical equipment.[18]
- **Strategy 2: Shorter inpatient stay with more intensive home treatment**—The patient receives only 6.1 days of inpatient therapy before being released to treatment in the home setting.[19]

When actual cost data were unavailable, Medicare reimbursement rates were used as a proxy for costs. Costs considered center on direct (medical expenses such as hospital, physician, and laboratory) costs. Indirect costs, such as treatment induced loss of productivity and wages, are considered to be equivalent between settings due to the nature of the disease. Because of the recurrent nature of COPD episodes and variability in duration of the illness, a discrete episode of hospitalization is analyzed and lifetime costs are not considered. Non-medical costs such as housekeeping, child care. and transportation are assumed to be equal between both treatment strategies and are not quantified in the analysis.

1. Calculation of costs

a. Inpatient Treatment

• **Hospital Inpatient Costs**—Medicare DRGs are used to calculate this amount. In FY 1990. DRG 88 had a weight of 1.0412, corresponding to a payment of **$3,497.68** to the average other urban hospital.
• **Physician Inpatient Costs**—Physician costs for inpatient treatment are similar to physician costs for inpatient/home treatment. The difference lies in the additional hospital stay associated with inpatient treatment. Thus, the initial expenditures will cancel out and the only relevant physician costs are visits during additional hospital days. We are assuming one physician visit per day. In 1988, CPT4 code 90260 corresponded to an allowable charge of $30.40 or $35.85 in 1990 dollars. The 1.4 day increase in inpatient stay corresponds to an extra 1.4 physician visits at a cost of **$50.19.**

b. Inpatient/Home Treatment

• **Inpatient Costs**—The hospital portion of the inpatient daily cost is derived by dividing the total DRG payment by the length of stay. To compute the inpatient costs incurred during the inpatient portion of an inpatient/home treatment program, we multiply the daily cost by the number of inpatient days. The average cost per inpatient stay is ($3,713.01 ÷ 7.5) * 6.1 = **$3,019.91.**
• **Physician Inpatient Costs**—Cancels out with physician visits described in the inpatient section.
• **Hospital and Physician Costs**—A study of home care for COPD patients indicates that home health care and clinic and emergency room visits are substitutes.[20] Therefore, additional costs are not assigned for these factors. It is assumed that the patient will make one physician visit per week corresponding to a cost of **$4.92** in 1990 dollars.
• **Home Health Agency Personnel**—A recent paper reports home health usage by Medicare patients for specific diagnoses. The number of home health visits to patients and the cost of a home health visit are provided in the table above. Estimates for charge per visit are 1987 charges inflated to 1990 dollars at a rate of 5.5% per year.[14] Assuming the length of an episode is three months, the charge per day can be calculated by dividing the total charges by total days ($1,213.71 ÷ 90). The charge for an additional 1.4 days of home health visits totals $18.88 (See Table 9). When 85% of charges is used as a proxy for costs, the total cost attributable to combination therapy is **$16.05.**

Table 9.—HOME HEALTH AGENCY VISITS PER COPD PATIENT

	Visits	Charge/Visit	Total charge
Skilled nursing	10.61	$74	$785.14
Home health aide	5.24	55	288.20
Physical therapy	1.19	75	89.25
Occup/speech/social work	0.72	83	51.12
Total			1,213.71

Source: Branch L. Goldberg H, Chet V et al.: Medicare Home Health Clients: Who Are They and What Service Do They Receive During an Episode of Care? Submitted to Health Care Financing Review, April 1990.

• **Home Medical Equipment, Supplies, and Services**—It is assumed that all COPD patients will require home medical equipment services upon discharge from the hospital. It is further assumed that inpatient/home treatment patients will require an addition 1.4 days of home medical equipment costs. Table 10 displays the monthly cost associated with home medical equipment, $609.71.[21] The cost associated with 1.4 days of equipment is **$28.06.**

Table 10.—HOME MEDICAL EQUIPMENT, SUPPLIES AND SERVICES USED BY COPD PATIENTS

Home medical equipment	Cost/month	Source
Oxygen—Stationary and portable	$322.84	Sample of Medicare Fee Schedules
Ventolin and aerosol inhaler	21.47	85% of Medi-Span, August 1990
Walker—Wheeled	22.12	Sample of Medicare Fee Schedules
Hospital Bed—Electric	195.73	Sample of Medicare Fee Schedules
Bedside commode	30.15	Sample of Medicare Fee Schedules

Table 10.—HOME MEDICAL EQUIPMENT, SUPPLIES AND SERVICES USED BY COPD PATIENTS—Continued

Home medical equipment	Cost/month	Source
Overbed table	17.40	Homedco Rental Price
Monthly total	609.71	

Source: Lewin/ICF.

2. Results

The results of the cost-identification analysis, detailed in Table 11, indicate that the reduction in inpatient stay of COPD patients in inpatient/home treatment saves approximately $450 per patient in health care resources. When quality of life is factored into the analysis, the cost savings attributed to inpatient/home therapy increases to $520 per patient. Thus, less intensive inpatient treatment (post-PPS) of COPD is both cheaper and more cost-effective than the longer inpatient treatment strategies. If the number of Medicare patients discharged from hospitals in 1990, 93,184 is used as an estimate of the number of patients with COPD requiring home oxygen therapy, society could save $48.5 million by choosing a treatment strategy that includes more intensive home care with a shorter inpatient stay.

Table 11.—COST COMPARISON OF TREATMENT OF COPD PATIENTS

Cost component	Inpatient treatment strategy 1	Inpatient/home treatment strategy 2
Hospital inpatient costs	$3,497.68	$3,019.91
Physician inpatient costs	+50.19	none
Outpatient hospital and physician costs	none	+4.92
Personnel	none	+16.05
Home medical equipment, supplies and services	none	+28.06
Total	3,547.87	3,097.75
Quality of life adjustment	+73.13	none
Adjusted total	3,621.00	3,097.75

Inpatient/Home treatment saves $450.12 per episode.
Inpatient/Home treatment saves $523.25 per quality-adjusted episode.

Notes:
A plus value in one column reflects an incremental cost.
Total costs are used for comparison only and do not reflect total cost of an episode.

IV. DISCUSSION

The analyses completed in the previous section for the three patient types (hip fractures, ALS with pneumonia, and COPD) find that a shorter hospital stay and a longer home care period is less costly in all cases. When quality of life is factored in, inpatient/home therapy is even more cost-effective than inpatient treatment alone (or the longer inpatient stay) for all of the patient types examined. We have identified a potential savings of between $300 and $2,330 per patient per episode (see Table 12).

The pressure on the providers to reduce length of inpatient stay as well as the development of locally-managed home medical equipment services that allow for more care in the home are largely responsible for these savings. Physicians are increasingly aware of the availability of home medical equipment and home health care services and factor these choices into their practice decisions. While health care costs have risen rapidly in the past ten years it should be recognized that, but not for the availability of home care services, the efficiencies we have observed throughout the 1980's may not have been achieved.

Table 12.—SAVINGS TO SOCIETY PER QUALITY ADJUSTED EPISODE

Type of patient	Savings per episode	Prevalence	Annual savings
Hip fracture	$2,300	250,000/year	$575,000,000
ALS with Pneumonia	300	1,533/year	459,900
COPD	520	93,184/year	48,455,680

Source: Lewin/ICF analysis.

ENDNOTES

1. Kahn KL, Keeler EB, Sherwood MJ: Comparing Outcomes of Care Before and After Implementation of the DRG-Based Prospective Payment System. *JAMA* 1990; 264(15): 1984–1988.
2. This paper was written in conjunction with several home medical equipment manufacturers and distributors.
3. However, over time HCFA realizes savings from a shift to home care it results in a reduction in the DRG weight, reflecting lower charges.
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9. The assumption of 15.9 days was used for length of stay based upon the average Medicare length of stay for DRG 211 in fiscal year 1981, prior to the time home care was expanded.
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11. Based upon average length of stay for DRG 211 in fiscal year 1989.
12. Fitzgerald JF, Moore PS, and Dittus RS: The Care of Elderly Patients with Hip Fracture: Changes Since Implementation of the Prospective Payment System. *New England Journal of Medicine* 1988;319(21):1392–1397.
13. Fitzgerald reports a post-PPS length of stay of 12.6 days which consists of 1.2 pre-operative days and 11.4 post-operative days. Applying these proportions to the FY 90 post-PPS length of stay reported in our study, 10.1, we estimate a total of 9.1 post-operative days (11.4 + 12.6 * 10.1). Fitzgerald also reports a 44 percent increase in physical therapy sessions per post-operative day. Adjusting the post-operative days to reflect this increase in physical therapy sessions, we arrive at a total of 14.1 adjusted inpatient days.((9.1 * 1.44) + 0.91).
14. Branch L, Goldberg H, Cheh V et al: Medicare Home Health Clients: Who Are They and What Services Do They Receive During an Episode of Care? Submitted to the *Health Care Financing Review,* April 1990.
15. Estimates taken from the Lewin/ICF Long Term Care Model.
16. For DME items that are purchased, costs are assumed to be 85% of charges.
17. American Lung Association, Fact Sheet on Chronic and Acute Respiratory Conditions.
18. Based on average Medicare length of stay in fiscal year 1981.
19. Based on average Medicare length of stay in fiscal year 1989.
20. Dranove D: An Empirical Study of a Hospital-Based Home Care Program. *Inquiry* 1985;22:59–66.
21. In accordance with dosing instructions, it is assumed that the patient inhales ventolin 10 times each day and that each inhaler contains approximately 200 inhalations. Therefore, during the month, the patient will use one inhaler and half of an inhaler replacement.

Prepared Statement of Senator William S. Cohen

Mr. Chairman, I would like to thank you inviting me to testify at this afternoon's hearing to examine ways in which we can better protect Medicare from fraud, abuse and inappropriate spending.

America's health care bill is expected to top $817 billion this year. Unfortunately, the recent explosion in health care spending has created a literal wealth of opportunities for a growing and increasingly sophisticated army of scam artists who have embarked on a spree of what one regulator has called "white collar wilding."

The GAO has just released a report estimating that health care fraud may amount to 10 per cent of all health care spending—as much as $80 billion a year. The American consumer foots the bill for this fraud and abuse, not only through tax dollars, but also through higher premiums that insurers charge because of the dollars lost to fraud. Fraud and abuse in our health care system also take away scarce dollars that otherwise could be used to provide services directly to the millions of Americans who are in need of care.

As our nation's largest payer for health care—and as the fastest growing major program in the federal budget—Medicare is a prime target for scam artists looking for ways to make a quick million or two off the system.

While the overwhelming majority of Medicare providers are dedicated and honest professionals, the rapid growth and sheer size of the program have greatly increased Medicare's vulnerability to fraud and abuse. Therefore, we must be vigilant in our efforts to ensure that sufficient safeguards are in place to detect and eliminate the few "bad apples" who try to rip off the system by billing for services or supplies that are unnecessary, inappropriate or of inferior quality.

Last fall, the Senate Aging Committee held a hearing which focused on the problems and potential for fraud and abuse associated with the current system used to assign provider numbers for those wishing to bill for Medicare services.

In order to do business with Medicare, a provider or supplier of health care services or equipment must first be issued a provider number. Under the current system, each Medicare carrier is responsible for assigning provider numbers to hospitals, physicians and medical supply companies in their area who wish to bill Medicare for their services.

Hospitals, home health agencies, and physicians must first meet state licensing and certification requirements before being Issued a provider number. However, most carriers do not keep track of their providers, and these numbers are rarely deactivated, even when the provider has lost the legal authority to practice. Lack of carrier oversight also enables providers to be issued multiple provider numbers, enabling them to double bill, overbill, or avoid being caught for fraudulent activities.

Glaring evidence of the carriers' failure to keep adequate records was provided last year when the Office of the Inspector General of HHS—which ironically had just completed an investigation of carrier maintenance of provider numbers—attempted to send out a fraud alert to Medicare providers using the carriers' records. Over 10,000 of the alerts were returned, stamped "not deliverable as addressed" because the provider had moved, was deceased, or was no longer in business.

The provider number system is even more lax for medical equipment suppliers. Durable medical equipment providers are not required to be certified or licensed In order to do business with Medicare. In fact, they do not have to meet any kind of standards whatsoever. The carrier will issue a number to any supplier requesting one—no questions asked.

This leaves the gate wide open to unscrupulous providers whose sole intent is to take advantage of Medicare beneficiaries and defraud the Medicare system. There are no standards to ensure that suppliers doing business with Medicare provide quality goods and services. There are no standards to ensure that the supplier has ties to the community or even that the supplier runs a viable business.

The current system is like the government issuing a lifetime Gold Card with an unlimited balance and no annual service fee to suppliers without first running a credit check.

Last year, the Minority Staff of the Aging Committee conducted an investigation of durable medical equipment (DME) telemarketers who were taking full advantage of the current weaknesses in the system to bleed millions of dollars from the Medicare program.

The investigation revealed shocking practices of fly-by-night operations which would establish "telephone boiler rooms" where teenagers and others with no medical backgrounds would be given lists of names and phone numbers of Medicare beneficiaries.

Call after call would be made to induce unsuspecting senior citizens to accept what was described as "free medical equipment"—equipment that was rarely needed, generally of inferior quality, and of little or no therapeutic value.

The telemarketers would then manipulate the Medicare system by shopping around for the states paying the highest reimbursement rate for equipment and supplies.

The examples of abuse are staggering:

- A plain piece of beige foam cost a DME supplier about $23, but was then billed to Medicare for more than $240 as a "flotation pad for a wheelchair."
- A simple heating pad that could be purchased through the Sears catalogue for about $23 was purchased by a DME telemarketer for $9.68, who then billed it to Medicare for $67. That is three times the Sears price and nine times the original purchase price.
- Finally, a bed-sized flimsy piece of pink foam was billed to Medicare as a "dry flotation mattress" to prevent bed sores. This item, which is next to useless, was purchased by a supplier for about $28 and then billed to Medicare for more than $1,100 in New York. That represented a profit of more than 3,800 per cent.

It is far too easy for fraudulent providers to gain access to Medicare. Currently, neither carriers nor HCFA do enough to police the Medicare billing system. The system for issuing provider numbers and ensuring the quality of items reimbursed by Medicare is far too lax and should be strengthened.

I have introduced legislation—the Quality in Medical Equipment and Supplies Act (S. 1988)—which takes several steps to guard against unscrupulous providers. It would, for example:

- require suppliers to meet strict criteria and disclosure requirements in order to obtain and renew provider numbers;
- require HCFA to develop a standard provider number application form and require suppliers to certify the accuracy of the information they provide;
- call for verification of the information given by providers through random audits and on-site inspection of supplier facilities;
- prohibit physicians from referring patients to suppliers in which the physician or a family member has an ownership or investment interest;
- guard against "carrier shopping" by suppliers by requiring suppliers to submit claims to Medicare only to the carrier having jurisdiction over where the patient resides;
- reduce the number of carriers paying durable medical equipment claims to five or less, in order to further prevent suppliers from "shopping the system" and to provide for better monitoring of DME claims; and
- call for uniform coverage and utilization criteria so all carriers will be paying the same reimbursement rates for items under the same circumstances.

The bill also includes provisions to encourage HCFA to consider the quality of items billed to Medicare, to discourage suppliers from selling inferior or even dangerous equipment to Medicare beneficiaries.

I am pleased that our investigation, as well as similar investigations by the Senate Budget Committee and others, have already had some results. Following the congressional hearings, HCFA proposed regulations that incorporate many of these ideas, and I understand that the Administration will soon propose a legislative package providing for more DME reforms.

I look forward to working with the Administration and the members of the Finance Committee to enact meaningful legislation to protect the Medicare program from fraud and abuse and to ensure that Medicare beneficiaries and the taxpayers get what they pay for—quality, medically necessary care.

Mr. Chairman, once again, thank you for calling this hearing and for giving me the opportunity to testify.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

Good afternoon, Mr. Chairman, and good afternoon, everyone.

I would like to thank the witnesses for being good enough to testify before the committee this morning. I'd like to particularly recognize those who travelled to be here today, from Arkansas, California, New Jersey, and Pennsylvania.

This year the nation will spend $129 billion on Medicare, making it a huge program and one of the two or three largest in the government. It's a sad reflection on human nature that anytime that much money is being spent there will be people who will engage in fraud and in abuse of the system that comes close to fraud.

This is a problem that goes beyond Medicare, of course. The FBI has said that 5% to 15% of the entire nation's health spending may be fraud—or between $60 billion and $180 billion. If true—and I guess no one really knows what the actual figure is—that's a truly awesome amount of crime.

And this is real crime—not just physicians disagreeing over whether a tonsillectomy for such-and-such a patient is justified. It's about billing for visits that never took place, medical equipment that was never intended to work and prescription medication that ends up being sold on the street corner.

When health-care costs are rising out of control, it's even more important to ensure that money is well-spent. The reason is that when payers are trying to contain costs every dollar wasted is a dollar that's not spent on care that will help people who are sick and need care.

I know the FBI is boosting the number of its agents working on health-care fraud from 38 two years ago to 150 agents now. I also encourage the Administration to do all it can—and more than it's doing now—to ensure our Medicare dollars are appropriately spent.

That will require close co-operation between the Medicare carriers, the Health-Care Financing Administration and the Office of the Inspector-General at Health and Human Services. And it will require that they co-operate with the FBI and local police—because the right place for some of the people involved in fraud and abuse is prison.

At the same time, there's a lesson here for how we fund health care. Large parts of Medicare are still financed through fee-for-service or reasonable cost reimbursement. These financing methods encourage more services and higher costs. Inevitably some participants in the system take advantage of these methods to bill for services never provided and costs never incurred.

One benefit of using diagnosis-related groups and capitation funding and other forms of managed care is that they make fraud and abuse harder to get away with. They make it harder to game the system. Managed care also means that some party reasonably close to the patient is thinking about how much money is being spent for what benefit, and can be alert to problems.

I now look forward to the testimony from our witnesses, and I turn the floor back to our chairman.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Thank you, Mr. Chairman. I want to start by telling you that I think it is a very good idea to have this hearing today.

The reason it's a good idea is that there are indications that a considerable amount of money, as much as a billion dollars a year, perhaps more, is being inappropriately spent by the Medicare program. Even in the context of Medicare, which is expected to spend around 150 billion dollars this year, this is a lot of money.

I have been interested in waste, fraud, and abuse in the Medicare program in at least two contexts, that of the durable medical equipment program and that of the payment safeguard function of the program with an emphasis on the Medicare secondary payer program.

I am looking forward to the testimony today from our colleague, Senator Cohen, who has introduced legislation to deal with some of the problems in the D-M-E industry.

My interest in the payment safeguards program was triggered by general accounting office reports to the effect that as much as one billion dollars was being spent each year unnecessarily by the program, and that as much as 2 billion dollars may be owed the program but remain uncollected.

In working on this issue, I was told by many objective observers, such as the Inspector General's Office and the General Accounting Office, that a major part of the problem has been that funding for the payment safeguard activities has been reduced substantially at the same time that the program has grown considerably.

This is unfortunate and short-sighted, given that every dollar spent on insuring correct payment, or on recoveries of inappropriately spent monies, returns to the program as much as eleven dollars, perhaps more.

Therefore, I introduced legislation, S. 2337, the Medicare Funds Recovery Act of 1992 to address this problem.

The legislation would provide an exemption from the budget act for the Medicare payment safeguard function so that funding for these activities could be stabilized so as to improve payment accuracy and validity, and to improve collection of monies owed the program.

It also requires the administration to provide improved information about monies recovered and to report to the Congress on the recovery program.

An exemption from the budget act was not my preferred approach, but, in working on this problem, I discovered that it seemed the only feasible way to insure adequate funding for these activities and thus to get about the business of reducing inappropriate payments and recovering the monies owed the program.

I also tried to include in the legislation some provisions that would not simply give the Health Care Financing Administration or the Medicare contractors a free hand, so to speak, with respect to funding.

One of the questions the bill does not address is how to identify primary payers for the Medicare secondary payer program.

Right now, as I understand it, the health care financing administration tries to develop this information through a "first claim development program" and through a data match activity required by Congress in 1989.

It's not clear to me how well the "first claim development program" works. Furthermore, employers and their benefits administrators complain about the burden the data match program imposes on them.

So, I am looking forward to hearing more about how we identify primary payers and whether we can improve how we do that.

I discussed these issues at some length on the Senate floor on March 5 and March 11 of this year, Mr. Chairman, and those who are interested in them can consult the *Congressional Record* of those dates for more comprehensive reviews of them.

Mr. Chairman, I will conclude by saying that program integrity in the Medicare program is very important. It's a very big and complicated program with plenty of opportunities for mis-spending the taxpayer's money. It's also a program that is under considerable budget cutting pressure, so we need to be sure we're not spending money inappropriately.

I think your hearing will help us get a handle on some of these problems, Mr. Chairman.

PREPARED STATEMENT OF SENATOR TOM HARKIN

Mr. Chairman: I recently introduced S. 2713, the Medicare Protection Act of 1992. This legislation, if enacted, would protect the Medicare Program from billions of dollars now lost to overpayment, fraud and abuse. This legislation, if adopted, would save an estimated $2 billion in its first year of operation.

Mr. Chairman, this is an issue that I have been following for sometime in my capacity as Chairman of the Labor, Health and Human Services and Education Subcommittee. The very first hearing I held as Chairman of the Subcommittee in February 1989 gas on this issue.

As you know, the Medicare program is managed by 64 different contracts awarded by the Health Care Financing Administration. These contracts are funded by an appropriation which in 1992 totaled $1.7 billion. Included within this line item for Medicare contractors is an amount of $324 million made available for audit activities. Even though these audit activities save $13 for every dollar spent, the Administration has never funded this audit activity at an appropriate level. This is because the need to process claims and make payments on time has always taken priority. In these times of fiscal stress this fact of life has held down funding for the audit activity.

In the spring of 1989 I had discussions with Senator Sasser, Chairman of the Senate Budget Committee and with Richard Darman, Director of The Office of Management and Budget. In these discussions I tried to reach agreement on excusing funds spent on audit activities in the Medicare program from budget ceilings. The precedent for doing that was included in previous omnibus budget reconciliation bills when the Finance Committee received spending relief by directing discretionary spending to be made by transfers from the trust fund to the audit activities of Medicare. Chairman Sasser and OMB Director Dick Darman, while sympathetic to my arguments, were unable to provide my Appropriations Subcommittee with similar relief.

Mr. Chairman, in the Budget Enforcement Act of 1990, another precedent for what I am now proposing was adopted into law. Included in that Act was authority for the IRS to spend up to specified amounts in each of five years on audit activities without these additional appropriations being scored against budget ceilings. The logic of this provision is that these additional expenditures will produce collections or revenues for the government well in excess of the actual amount spent. The logic of this provision is that to unnecessarily inhibit spending on these audit activities is counter productive to our efforts to reduce the deficit.

Mr. Chairman, this bill is based on exactly the same logic that supports increased funding for IRS audit activity.

The Medicare Program Protection Act of 1992 will encourage, for each year, starting with fiscal year 1992, through fiscal year 1995, audit activities of the Medicare contractors appropriation to be set at a level of 11.6% over the previous year's level. This increased amount over the freeze level would not count against the budget ceilings. These increases in audit activity will permit substantial savings each year.

It is my view that these audit activities should at least keep up with the increased growth rate in claims if we are to have adequate protection for taxpayer dollars. The

11.6% allowable growth is included in the legislation as it represents the ten year historical average of growth in Medicare claims workload.

Mr. Chairman, the Medicare Program Protection Act of 1992, if enacted, would save approximately $2 billion in the first full year of implementation and additional billions for each year through fiscal year 1995. It is my hope that the members of this Committee will actively support this legislation.

PREPARED STATEMENT OF MICHAEL MANGANO

Good morning Mr. Chairman and members of the subcommittee. I am Mike Mangano, Deputy Assistant Inspector General of the Office of Inspector General (OIG). Thank you for the opportunity to testify on the subject of health care fraud in the Medicare program. We are aware that the subcommittee has been actively involved in health care financing issues. The area of health care fraud is also of great significance as it squanders our valuable resources and can adversely impact the health of our beneficiaries. Thus, herrings such as this help heighten awareness of these important issues.

THE ROLE OF THE OIG

The Department of Health and Human Services (HHS) is the Federal Governments principal agency for promoting the health and welfare of Americans and providing essential human services to persons of every age group. The OIG is statutorily charged to protect the integrity of departmental programs, as well as, promote their economy efficiency and effectiveness. We meet our challenge through a comprehensive program of audits, inspections, program evaluations, and investigations.

Funding spent on the Office of Inspector General (OIG) 1s a sound investment. In fiscal year 1991, the Department of Health and Human Services spent almost $200 billion for the health care of more than 50 million beneficiaries. During that period, each dollar invested in our office resulted in savings to the Federal Government of $72. In addition, fiscal year 1991 marked our 11th consecutive increase in investigative accomplishments. Of the 2,348 successful criminal prosecutions and administrative sanctions we attained last year, nearly half were directly related to health care. The OIG's successful health care prosecutions in the criminal courts rose from 20 in fiscal year 1982 to 163 in fiscal year 1991, an increase of 800 percent. An even more dramatic increase has taken place in the number of civil actions (in the form of exclusions and monetary penal ties) that we have taken against individuals and entities. In fiscal year 1991 alone, over 1,000 administrative sanctions were imposed on individuals and entities who defrauded or abused the Medicare and Medicaid programs or their beneficiaries. This is more than 3 times the number of sanctions imposed 5 years ago and 32 times the level we reported in 1981.

These increases in output were accomplished despite the fact that we have had virtually no increase in investigative resources since our consolidation in 1982. In fact, the rate of expansion of the health care programs we oversee has far outpaced any increase we have had in resources, causing us to stretch our resources to the limit.

Currently Americans are devoting more than 12 percent of our gross national product (GNP) to health care. Roughly three quarters of a trillion dollars were spent in this country on health care last year. This figure is expected to rise dramatically—one projection indicates that health care expenditures could consume 31.5 percent of our GNP by the year 2020. Federal outlays for Medicare and Medicaid alone are expected to be about $230 billion in fiscal year 1993. Today over 50 million Americans rely upon Medicare and Medicaid. Other health care programs funded by HHS include the Indian health service, maternal and child health, and community health centers. The OIG has been long engaged in anti-fraud activities directed at these programs. And we have testified before the congress many times on the results of our work

FRAUD AND ABUSE

The rapid rise in health care expenditures and deficiencies in our health care delivery system has caused unprecedented attention and scrutiny to the health care area. This scrutiny has encompassed discussions regarding the magnitude and pervasiveness of fraud, waste, and abuse in our health care programs. As you know the general accounting office (GAO) recently released a report entitled, "Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse." The report quotes unnamed experts in the health field who estimate the losses to fraud and abuse in

health care were 10 percent or $70 billion in 1991. This estimate has caused a great deal of concern to the public and those who serve the public.

While we have no empirical way of estimating the amount of fraud and abuse in the public or private health care sectors, we can safely assume that a great deal lies in the private sector. This is because so little has been done in this area. Until recently private health insurance programs had no significant investigative response to fraud.

To address this issue, in 1985 we helped launch and were one of the founding members of the National Health Care Anti-fraud Association (NHCAA). It is a consortium of our office, the Department of Justice (DOJ), Federal Bureau of Investigation (FBI), State Medicaid Fraud Control Units (MFCUs), private health insurers, and others who coordinate and share information and techniques in dealing with health fraud. Our office has been on the board of directors from its inception. In addition to working on joint projects with this group, we help train them in better detection techniques and alert them to new types of health fraud.

Prior to the inception of the NHCAA, private carriers did not have a means to share information in order to enhance the identification, prevention, detection, and prosecution of health care fraud. NHCAA was established on the premise that the diverse interests of health insurance reimbursement organizations, blue cross and blue shield organizations, private corporations and Federal and State agencies and law enforcement operations could be channeled toward a common goal. The association currently consists of several hundred representatives from these types of organizations. NHCAA promotes information sharing among members (with appropriate legal safeguards), engages in public education on health care fraud issues, trains members and non-members through national and regional conferences, seminars, and workshops, and serves in an advisory capacity to industry regulatory and legislative bodies.

While the NHCAA provides a valuable service, there are still problems in the private sector which could be strengthened by an increase of the sharing of information concerning health care fraud and abuse and training of investigators in conducting white collar crime investigations. Legislative action is needed to enhance and solidify the exchange of information and to support the efforts and goals of associations such as NHCAA.

In discussing monetary losses to our health programs, a distinction must be made between fraud, abuse, and waste. It is impossible to distinguish sharply between these terms since frequently one problem involves all three. However, for purposes of rough definitions, we provide the following:

- Fraud is defined as the obtaining of something of value, through intentional misrepresentation or concealment of material facts.
- Abuse may be defined as any practice which is not consistent with the purpose of Medicare and Medicaid—which is to provide program beneficiaries with medical services which are (1) medically necessary, (2) performed competently, and (3) at a fair price.
- Waste is the incurring of unnecessary costs as a result of deficient practices, systems, or controls.

Fraud is invisible until detected, and because of that fact, it is extremely difficult to put a dollar figure on the total amount of fraud in the health care industry. While we cannot determine the extent of fraud in HHS health programs at this time, we have noticed a dramatic increase in our investigative workload. One of the factors causing this is the enormous growth of program outlays. Increased detection has also been brought about by improved coordination of effort by our office with the NHCAA, MFCUs, other offices of Inspectors General, the Postal Service, the FBI, the DOJ, and private health insurers. For example, we have provided numerous technical assistance manuals to the MFCUs, including manuals entitled "Checklist for Surveying Patients' Personal Fund Accounts," "Investigation Guide for the Detection of Patient Abuse," "Pharmacy Investigative Guide," and "Laboratory Investigative Guide."

In preparing for this herring, you specifically requested that we address those areas posing the most significant potential for health care fraud. As you know, the OIG has dealt with a host of problems over the years, far too numerous to list. Therefore, we have selected examples of areas that merit further attention and that clearly demonstrate patterns of fraud or vulnerabilities to fraud in our health care system. Before moving on to these specific areas of concern, I want to mention that we have been very concerned with program efficiency and the solvency of the Medicare trust funds. While these recommendations are not our focus today, I do want to reference our "cost savers handbook," referred to as the "Red Book." The Red Book is a compendium of significant OIG monetary recommendations based on our

audit and inspection reports. We prepare the Red Book annually to provide departmental decision-makers, administration officials and members of Congress with a tool for evaluating actions that might be taken to achieve savings and improve program efficiency. Our spring 1992 edition describes 100 possible cost saving opportunities, including 45 directed to the Medicare and Medicaid programs. The aggregate of the savings options represents a potential of more than $26 billion in annual savings to the Department's programs.

I. Durable Medical Equipment (DME)

DME includes oxygen equipment wheel chairs, transcutaneous electrical nerve stimulators (TENS), seat lift mechanisms, and other equipment and supplies that physicians prescribe for home use. Expenditures for DME now are approaching $3 billion a year. For many years, we have worked with the DME industry to document fraudulent and abusive practices, including questionable marketing techniques, inflated charges, and manipulation of loopholes in the law. Not only is the Federal Government losing millions of dollars a year on these schemes, but these practices are particularly offensive because they victimize our beneficiaries.

We are pleased that our work in this area has contributed to the heightened awareness of the deficiencies in DME reimbursement. We have issued numerous reports on this subject and I would be happy to make these available to the subcommittee. We have also aggressively pursued those who have defrauded our programs in this area. In the last 3 years alone, over 80 convictions have been obtained in this area.

We have had a half dozen congressional hearings over the last year on this issue alone. These hearings have contributed to additional research in this area and the Department has under taken a major DME reform effort. This reform effort consists of administrative and regulatory changes as well as the submission of legislation affecting DME.

Even with the reform effecting carrier jurisdiction and provider numbers (which will not be effective until 1993), we believe that additional corrective action should be taken. The current system will continue to allow some variation in reimbursement rates for DME. We support a national single pricing schedule established for all DME that could take into consideration local market variations. We also support improved definitions for DME and believe that the medical effectiveness of some equipment should be reviewed. HCFA is currently developing definitions for the "top 100" used/abused DME codes. We applaud this effort and look for ward to additional HCFA initiatives.

We also believe that revisions should be made to the certificate of medical necessity (CMN). A CMN is a verification or a justification that there is a medical reason to prescribe specific DME equipment or supplies. Because of high pressure marketing techniques used by some suppliers, some physicians merely sign CMNs without question. In other instances, DME companies deliver equipment before medical approval is given and later repossess the equipment if the CMNs are not signed by the physician. Even if the patient's physician objects to a DME supplier's request for approval of a piece of equipment, some DME companies will either enlist a coconspirator physician to sign the form or even forge the physician's signature. Also, the CMN may be altered after the physician has signed it, to include equipment for which the patient has no need, or to include false diagnoses.

The CMN requirement is intended to place the responsibility for determining medical necessity for DME with the physician. The DME supplier usually is successful in asserting reliance upon the signed CMN as a defense against carrier overpayment recovery efforts and criminal prosecution. However, there is no specific incentive to the physician to exercise due care before signing the CMN.

To improve assessment of the medical necessity of DME equipment and supplies, we believe that information pertaining to the physician's role in the beneficiary's treatment, the plan of treatment, and a justification for the need of the DME should be included in the CMN. Additionally the physician should not be allowed to sign the CMN more than 45 days after last examining or treating the patient. The CMN should also include a statement that willful and intentional misrepresentation of fact constitutes fraud and may subject the physician to criminal prosecution, civil monetary penal ties, and/or exclusion from the Medicare and Medicaid program.

OBRA '90 attempted to address CMN abuses by prohibiting suppliers from providing physicians or beneficiaries with completed or partially completed CMNs. These provisions went into effect in 1991. However, we notice some DME suppliers are now sending instructions for the completion of the CMN to physicians, in order to ensure Medicare will pay for the items being sold. We believe that these actions continue to undermine the effectiveness of the CMN requirement.

II. Medicare Secondary Payer Activities

Medicare fiscal intermediaries and carriers are responsible for conducting payment safeguards, activities which include medical and utilization reviews, audits, and Medicare secondary payer activities. HCFA is responsible for overseeing and evaluating these entities which are collectively known as Medicare contractors.

Medicare is the secondary payer to certain employer health plans for beneficiaries age 65 and older, disabled beneficiaries, and during the first 18 months of a beneficiary's entitlement to Medicare on the basis of end stage renal disease (ESRD). Medicare is also secondary payer to workers' compensation benefits and to automobile, liability and no-fault insurance coverage. Identification of Medicare secondary payer (MSP) situations occurs through a variety of means: beneficiary questionnaires, provider identification of coverage when services are provided, and data matches.

Over the last several years, HCFA has actively pursued several initiatives, including legislative proposals and the filing of suits against noncomplying insurers, to improve the MSP program. Savings for fiscal year 1991 were $2 billion. These savings were achieved at a cost of approximately $1 in administrative costs for every $30 saved for the entire MSP program. Nonetheless, it is estimated that the Medicare program may be paying out as much as $1 billion a year unnecessarily because insurers, underwriters, and third party administrators often do not pay as primary payers when they are so required and because Medicare fiscal intermediaries and carriers do not always identify the primary payers.

Reviews by OIG reaffirmed HCFA's awareness that billions of Medicare dollars have been spent on claims which should have been paid by another, primary insurer. For example, auditors found that a Florida carrier was not processing MSP claims. An inspection was then conducted to evaluate the procedures used by other Medicare carriers to identify primary payment sources. The OIG found that the fiscal year 1990 budget reductions for MSP activities have adversely affected the carriers' ability to handle the MSP workload. Carriers were identifying most MSP cases, but they lacked the resources to recover mistaken payments created when previous claims were improperly paid by Medicare. Inadequate funding for payment has resulted in the loss of adequate contractor staffing levels in the payment safeguards areas and lack of recovery action on Medicare secondary payer overpayments, including some cases where the government's collection rights will expire in the near future. In addition, OIG identified inconsistencies in methods used to identify and calculate savings from payment safeguard activities.

We recommend that HCFA revise all Medicare claims forms to require the submission of spousal insurance information before the claims can be paid. In addition, HCFA should prioritize the information received from the Social Security Administration and develop those cases with an indication of a working spouse. Also, the OIG recommends the establishment of a voluntary disclosure and recovery program whereby insurers, employers or third-party administrators would be allowed to make restitution of mistaken payments without threat of future government action on those claims. Further, OIG recommended that HCFA propose legislation to require insurers to provide their health insurance data, including eligibility and claims information, to HCFA and to require Medicare contractors to match their private health insurance records with Medicare files.

HCFA should also consider the development of a legislative proposal that would allow for demonstration programs to evaluate the effectiveness of a carrier incentive program for MSP recoveries. We estimate such an incentive program could generate savings ranging from $199 to $361 million.

III. Kickbacks

Now I would like to turn to the issue of kickbacks. Physician ownership of and compensation from entities to which they make referrals is a practice that has increased considerably in the last 10 years. Many physicians have financial relationships with laboratories, DME suppliers, nursing homes, ambulatory surgical centers, and home health agencies. Research continues to determine the extent to which increased costs are a problem for other items and services that these joint ventures furnish.

Under the Medicare and Medicaid anti-kickback statute, section 1128B(b) of the Social Security Act it is illegal to offer or pay a profit distribution to a physician to deliberately induce them to refer business payable under Medicare or any State health care program. Our office initiated civil prosecution of three limited partnership laboratories and its principals in *The Inspector General* v. *The Hanlester Network, et al.* in this case, for the first time, it has been established that a joint venture scheme can violate the anti-kickback statute. In other words, it has been shown that a dividend payment from a joint venture to a referring physician can, under

many common circumstances, be just a disguise for an unlawful kickback all the defendants in the case were found to have engaged in illegal kickbacks, and the case is now on appeal.

Last year, final safe harbor regulations were promulgated. These long awaited regulations define for health care providers specific non-abusive business arrangements that will not be subject to prosecution under the anti-kickback statute. One of the provisions provides very limited protection to physicians and other health care providers who invest in entities to which they refer business. This tightly drawn safe harbor will hopefully lead to a restructuring of many joint ventures as providers for the first time are able to have the comfort of knowing that they are conducting business legally. The safe harbor regulations should also facilitate prosecution of the seriously abusive joint ventures because we are now able to show courts that those who choose to operate outside of the safe harbors can no longer claim that they are confused about how to operate a lawful joint venture. We believe that the combination of changed provider behavior coupled with more effective enforcement is the best that can be achieved under current law

Since 1987, we have received more than 1,250 allegations of violations of the anti-kickback statute, and have opened over 800 cases. Over 550 convictions, settlements, and exclusions have been obtained as a result of our investigations, as well as almost $16 million in monetary recoveries.

We note that one mechanism used to sell superfluous and exorbitantly priced equipment is to waive—in other words, not bill for—copayments and deductibles under Medicare part B. A "copayment" is the portion of the cost of an item or service which the Medicare beneficiary must pay the "deductible" is the amount that must be paid by a Medicare beneficiary before Medicare will pay for any items or services for that individual. We issued a special fraud alert to over 800,000 health care providers, practitioners, and suppliers, on the routine waiver of Medicare copayments or deductibles. The fraud alert states that routine waivers are illegal for charge-based providers because they result in false claims, violations of the anti-kickback statute, and excessive utilization of services and items. It points out that anyone who routinely waives the copayment or deductible is misstating actual charges. These persons could be considered as doing so to generate business, and could be encouraging unnecessary use by Medicare beneficiaries of "free" services.

We have also evaluated the kickback area from other perspectives. In 1989, the OIG released several reports summarizing the financial arrangements between physicians and health care businesses to which they refer their patients. The most important of these reports, "Financial Arrangements Between Physicians and Health Care Businesses: Report to Congress," found that 12 percent of physicians who bill Medicare have ownership and investment interests in entities to which they make patient referrals. We also found that such arrangements were associated with increased utilization of services. Patients of referring physicians who own or invest in clinical laboratories received 45 percent more services than Medicare patients in general. We estimated that this increased utilization of laboratory services by patients of physician-owners cost the Medicare program $28 million. The Congress used these findings to pass legislation to outlaw physician ownership in clinical labs to which they refer patients.

In January 1991, we issued a management advisory report entitled "Financial Arrangements Between Hospitals and Hospital-Based Physicians" in which we describe certain arrangements which could violate the anti-kickback statute. We looked at the fees hospitals receive from physicians who are dependent upon referrals of business in hospitals, like radiologists and anesthesiologists. We found several types of fees which are in excess of the fair market value of the services the hospitals provide to physicians, and are therefore suspect.

We have just distributed a new fraud alert which addresses hospital incentives to doctors who refer patients to hospitals. Some of the highly suspect features here include free or low cost rent in office buildings adjacent to the hospital, free or low cost access to equipment or nursing, billing and receptionist services, income guarantees, and "loans" to the doctors, which are forgiven if a lot of business is referred.

We have also examined the range of drug promotion practices that involve physicians receiving money or other items of value from pharmaceutical companies. In a report entitled "Promotion of Prescription Drugs Through Payments and Gifts," we assessed the vulnerabilities such practices present and examined the responses of government and private groups to inappropriate or illegal practices. We found that pharmaceutical companies offer money and other items of value to physicians for a range of purposes, from sponsoring important educational activities to actively promoting their products. These promotional practices appear to affect physicians' prescribing decisions. Accordingly, we are currently investigating kickback cases in-

volving promotional practices of pharmaceutical companies. We are also studying the effect of safe harbors on small entities.

Last year, we issued a draft report entitled "Review of Medicare Payments for Home Blood Glucose Monitors." This report examined Medicare payments for glucose monitors and the impact manufacturer rebates had on reimbursement levels. Our review disclosed that excessive Medicare payments were made for monitors because claims were not adjusted to reflect manufacturers' rebates. In our sample of claims where rebates were available at the time of purchase, we found that only 10 percent of the claims were properly reduced by the amount of the rebate, resulting in potential overpayments for the remaining 90 percent of claims. We also found that fee schedules established for glucose monitors were excessive.

Manufacturer rebate programs, such as those offered on blood glucose monitors, make it difficult for Medicare to account for the rebate amount in computing the proper allowed payment to create a financial disincentive to establish these programs, we support changes to the anti-kickback statute which would allow for the imposition of civil monetary penal ties for failure to comply with the statute.

IV. Investigations of Home Health Agency Fraud

Home health agencies (HHA) provide care in the patient's home, with limited supervision by the attending physician. Thus, there is vulnerability to a variety of fraud schemes. While most HHAs are certainly legitimate operations, a few are outright dishonest. Since 1986, we have successfully prosecuted 22 HHAs and their employees for Medicare fraud. In the last 2 years, we have excluded 16 HHAs, owners or employees from participating in Medicare.

There are several categories of fraud which we have seen in HHA operations and which we believe occur throughout the United States. These include: cost report fraud; excessive services or services not rendered; use of unlicensed or untrained staff; falsified plans of care and forged physician's signatures; kickbacks and intermediary hopping. Let me briefly discuss each category.

The first type of scheme involves falsifying HHA annual cost reports. These reports, which are subject to audit by the intermediaries, are the basis for determining the allowable costs of furnishing services and determining Medicare's share of those costs. Attempts to write off items not used in providing care to beneficiaries represents the largest single area of fraudulent activity we have identified.

The second scheme involves excessive services or services not rendered. Home care services must be (1) ordered in a "plan of care" prepared and periodically reviewed by a physician and (2) furnished by a participating HHA, either directly or through arrangements with others. An HHA should provide only those services which the physician orders. However, we have seen instances in which the HHA directed nurses and aides to make unnecessary visits, or to falsify documentation in an effort to make it appear that necessary visits were made.

Ssometimes, services maybe provided by unqualified individuals. We have been concerned with this for some time while congress has addressed it previously additional corrective action is required. The scheme of using unlicensed or untrained personnel is generally part of a larger pattern of fraud.

The physician's role in authorizing home health care is critical. Although the HHA may evaluate the patient to determine whether the requirements for Medicare coverage are met, it is up to a physician to certify (and periodically recertify) the medical need for home health care and to establish a plan of care. It is important to note, however, that the physician who performs these tasks is not required to actually see the patient.

Once the certification and plan of care have been obtained, the HHA deals directly with the intermediary in submitting claims for reimbursement. We have found that some unscrupulous HHAs will submit claims for services which are not included under the original plan of care. If the patient's physician refuses to sign a plan of care we have found that some HHAs simply forge his signature to the document and submit it without his knowledge.

Patients can use a HHA of their own choosing, but a "recommendation" made by a hospital discharge planner, a social services representative or someone else in whom the patient or their family place their trust will carry great weight. HHAs may arrange to place discharge planners in hospitals at no charge to the hospitals. The discharge planners then refer *all* patients to the HHA that pays their salaries, unless they receive specific instructions from the patient or the patient's family to do otherwise. We are investigating arrangements such as these as potential violations of the Medicare anti-kickback statute.

We have also observed a proliferation of business arrangements which are intended to enhance the investment potential of health care related businesses by appealing to investors who are in a position to direct a stream of referrals to their

business. Hospitals, physicians and other potential referral sources have become involved in the HHA field as owners or investors. Further, we have seen a growth in transactions between HHAs and suppliers who share common ownership in an effort to inflate the amounts which Medicare will reimburse. This is often a difficult scheme to detect, even by the most skillful auditor.

Finally, HHAs are paid during the year based on their estimated costs, and the intermediaries make final settlements based on the amount of actual costs found to be reasonable under Medicare's cost-reimbursement rules. Beginning in 1979, HCFA established limits that Medicare will pay for home health care. Separate limits are set for rural and urban HHAs because costs tend to differ between them. Accordingly, HHAs know in advance the maximum amount they can receive for providing each service.

Claims for home health services are submitted to the regional Medicare intermediary serving the geographic area in which the HHA providing the services is located. The HHA has the right, however, to elect another intermediary under circumstances which would be more efficient for claims processing. This change must be approved by HCFA.

Variations in coverage policies can lead to the practice of "intermediary hopping." Under this practice, HHAs shop around, learning as much as they can about each intermediary's coverage policies. They learn which intermediaries pay the most for home health care in an effort to obtain maximum reimbursement for their services. Armed with this information, some HHA chains move their home office operations to a location served by the intermediary with the most favorable coverage policies. This subverts Medicare guidelines regarding intermediary jurisdiction.

V. Reimbursement Manipulation

Billing is another significant area where our work has found patterns of fraud. Many fraudulent billings involve the artful manipulation of HCFA reimbursement rules. Types of coding manipulation include upcoding, recovery billing, and "unbundling."

Upcoding is a relatively simple process of billing a service using a code for similar, but slightly more complex service. This results in a higher reimbursement rate than is appropriate for the service which was actually rendered. For example saying a patient had a stroke ("a cerebrovascular accident") instead of a less-serious transient ischemic attack would mean approximately $1,450 in additional payment to the average hospital. Similarly, calling the removal of a small wedge of tissue (for a biopsy) a "resection" could mean as much as $9,000 overpaid per procedure.

In a draft report entitled "National DRG Validation Study Update: Summary Report," we identified 14.7 percent rate of DRG miscoding for 1988. This rate was statistically significantly lower than the 20.8 percent which the OIG found for 1985 (the net effect on payment was a projected overpayment of $308 million in 1985). Only 51 percent of DRG errors over-reimbursed the hospitals in 1988. This is an improvement over our 1985 finding of 60 percent of errors resulting in overpayments. Overall, by 1988, hospital coding errors were no longer causing significant over reimbursements.

In addition, we have completed a study that has documented a related issue, entitled "Hospital Acquisition of Computer Software Programs Under the Prospective Payment System: Effect on Case Mix Index." This report, released in January 1990, assessed the possible impact of computer software used in medical records departments on Medicare reimbursement. Many of these software packages contain a feature, called an optimizer, which can, among other things, rearrange Medicare codes. This so called "maximization" is the deliberate act of selecting and sequencing the codes which will result in the highest possible reimbursement, without concern for their substantiation in the medical records. While this study found no overall impact from the use of optimizers, we continue to be concerned with the potential misuse of this equipment. A case involving a small hospital which used software to upcode resulted in a civil settlement in excess of $3 million.

In recovery billing, consultants review provider records over a specified period and identify "unbilled services." The billing agent typically audits patient records to identify services for which the provider had failed to bill.

While such action is perfectly legal, other activities of the consultants are illegal and unethical. These other activities include "misinterpreting" entries in the records or by simply making them up, upcoding, and unbundling. These unbilled services are submitted to third party payers for reimbursement. In addition to costing patients, insurance companies, and the Medicare program millions of dollars, our concerns with these billings take on alarming and new meaning in light of the growing sophistication being demonstrated by those submitting recovery billings to Medicare.

Our investigators have been identifying numerous instances of fraudulent recovery billing.

We are also concerned about the practice of "unbundling," which is a practice in which health care providers submit bills piecemeal rather than for the procedure or product as a whole. We believe that these practices are unethical and contribute significantly to rising health care expenditures.

VI. Laboratory Fraud

We are also concerned about the effect and extent of fraud in the laboratory area. The basic system behind laboratory billing is that each test procedure (identified by a specific code number) is reimbursed, usually according to a fee schedule. Physicians must order these tests. Most patients have little or no comprehension as to what specific tests are ordered, the reasons behind them, or even what laboratory performs them. This situation makes fraud that much more subtle, especially if the physician is involved in the fraud. I would like to provide summaries of the most common types of laboratory fraud schemes.

The first scheme is to submit claims for services never rendered. In addition to costing Medicare millions of wasted dollars, this simple scheme can have disastrous results as it pertains to the patient. If the test was ordered by the doctor, the fictitious results provided by the laboratory give a false picture of the patient's physical condition; if the tests were not ordered, the false results may affect later diagnoses or unnecessarily muddle the present patient evaluation, possibly causing additional expense.

The second scheme involves unauthorized or excessive tests. A laboratory should perform only those tests which the physician orders. Many times, however, a laboratory will perform and bill for tests never ordered and which are not medically necessary. In order to facilitate this scheme, a laboratory will supply the physicians with an order form which will link tests to one another, even if not warranted. This results in the physician ordering tests A and B, when all that was really needed (and wanted) was test A. Occasionally, the laboratory will actually perform the test ordered, but will bill for a related, more expensive one.

In the last 5 years, almost 50 convictions and civil actions have been obtained as a result of our laboratory investigations. We believe that laboratory fraud is particularly serious in light of the expansions of new technologies, and the identification of life threatening diseases, as well as the critical need for early detection of certain illnesses. Thus, laboratories are one of the many areas that the OIG has focused on over the years.

VII. Hospital Credit Balances

In a draft report entitled "Update on Findings Developed in our National Review of Medicare Accounts Receivable With Credit Balances," the OIG documented that the Medicare program was losing millions of dollars because Medicare credit balances were not being returned to the government. A credit balance in a Medicare account occurs when a hospital records a higher reimbursement than the amount charged for a specific Medicare beneficiary. A credit balance may be due to an accounting error or it may be due to an overpayment to a hospital from either an intermediary or another insurer.

We found that most hospitals are not routinely reviewing Medicare credit balance accounts to identify Medicare overpayments for refund to the intermediary. Specifically, we found that hospitals owe the Medicare program about $266 million as a result of Medicare overpayments Medicare credit balances but not refunded to the intermediaries. The chief causes of these Medicare overpayments are: duplicate billings to Medicare, services being reimbursed by another insurer as well as Medicare, and services being billed but never rendered. Hospitals often do not attempt to identify and refund overpayments to intermediaries.

We also found that intermediaries are not aggressively monitoring hospitals to identify and recover Medicare overpayments. Hospitals which do attempt to refund overpayments to intermediaries are often unsuccessful because intermediaries are not always responsive to hospitals' efforts to return the amounts inappropriately paid. Some hospitals are writing off Medicare credit balance accounts and retaining money owed the government.

We are currently conducting an analysis to determine if a similar situation exists in the Medicaid program. Our preliminary findings are that credit balances do exist but the monetary impact is not as great.

VIII. Other Program Noncompliances

In addition to activities which can be deemed purely fraudulent, Medicare program losses which result from noncompliance with program rules and regulations reach into the billions of dollars annually. While MSP is the most dramatic area

of noncompliance, our office has been actively involved in identifying other areas of noncompliance and in assuring that recoveries are made and that program modifications are made to prevent further losses. Here are a few examples:

- In a March 1991 report, we documented losses to the Medicare program in excess of $8 million in one region (from January 1, 1985 through November 30, 1987) because transfers from hospitals were erroneously reported and paid as discharges.
- In a may 1992 draft report, we estimated that about $38.5 million in improper payments for nonphysician outpatient services were made to hospitals. These improper payments were made because adequate computer edits and controls were not implemented at the hospitals' and the fiscal intermediaries' claims processing systems.
- An April 1992 review disclosed that fiscal intermediaries made approximately $15 million in overpayments to independent dialysis facilities for separately billable drug and blood services. The review disclosed that most fiscal intermediaries did not have adequate internal controls to ensure that the claims for separately billable drug and blood services were paid in accordance with HCFA guidelines.

CONCLUSION

In attempting to reduce fraud, waste, and abuse, we do not simply react to individual events or complaints, but rather take a broader and more proactive approach. Our philosophy has been and continues to be to employ our limited resources in a balanced fashion to identify and prosecute wrongdoers, recover unjust enrichments for the programs, publicize actions to increase deterrence, and finally reduce vulnerabilities and risks with corrective actions.

Over the years we have risen to that challenge and continued to produce quality investigations and successful prosecutions at a rate considerably higher than program expansion rates. It has become increasingly more difficult.

PREPARED STATEMENT OF SENATOR GEORGE J. MITCHELL

Thank you Mr. Chairman for calling this hearing today to examine ways to diminish fraud and abuse in the Medicare program. I commend you on your dedication to this issue and your efforts to find ways to end abuse within our health care system.

Fraud and abuse in our health care system has a direct impact on health care cost inflation and access to services. It is an element of our health care system that affects the integrity of every component of the system—practicioners, suppliers, carriers, and public programs.

The General Accounting Office recently published a report on the billions of health care dollars lost to fraud and abuse. The GAO found that vulnerabilities within the health insurance system allow unscrupulous health care providers to cheat insurance carriers and public programs out of billions of dollars annually. They estimate that approximately $70 billion—10% of our total health care spending—will be lost to fraud and abuse this year alone.

This is unacceptable. Our nation is facing rapidly growing health care costs that consume 12 percent of our gross national product. We are also facing a growing uninsured population that has reached 37 million Americans. The amount of money unscrupulously stolen from the system has a direct impact on the health care cost and coverage problems our society is facing. We cannot afford to tolerate this blatant abuse.

The health care system of this nation is in a crisis and all the efforts to reform the system to control costs and assure access will not succeed unless the incentives for fraud and abuse within the system are removed.

I thank you again Mr. Chairman for addressing this issue today and I look forward to hearing the testimony of your witnesses.

PREPARED STATEMENT OF CORRINE PARVER

Mr. Chairman and Members of the Committee: I am pleased to discuss the important role the home medical equipment (HME) services industry plays in helping curtail unnecessary Medicare expenditures. I am Corrine Parver, President and Chief Executive Officer of the National Association of Medical equipment Suppliers (NAMES), the national trade association representing the HME industry. NAMES is a non-profit association representing over 2000 HME suppliers operating in over

4500 facilities nationwide. Accompanying me is Jim Liken, NAME Board member and President of Liken Medicare Center, with facilities serving home care patients in Pennsylvania and West Virginia.

According to physicians' prescriptions and determinations of appropriate medical need, NAMES members furnish a wide variety of equipment, supplies and services to Medicare beneficiaries for home use. These items rage from traditional medical equipment such as hospital beds and walkers to highly sophisticated services such as oxygen ventilators; parenteral and enteral supplies, which provide nutrition via equipment to individuals who cannot eat normally; apnea monitors, which allow parents to closely guard high-risk infants' breathing; and technologically-advanced equipment such as power wheelchairs, which are custom-designed for persons with severe disabilities to help enable them to lead more independent lives.

My testimony focuses on two main issues:

- How, together, we must mount an effective program to streamline Medicare administration and increase efficiency through a targeted and well-thought-out campaign and to identify and eliminate abusive and unethical practices among *all* Medicare providers (including HME suppliers) through legislation and consumer education that will ensure quality care and ethical behavior; and
- The cost-effectiveness and social value of HME in our nation's health care system.

As you know, HME outlays represent approximately 2% of annual Medicare program expenditures. Despite the relatively small dollar outlays expended on HME, the industry has for several years borne the brunt of repeated Congressional budgetary attempts to reduce Medicare expenditures by seemingly singling out the HME industry as riddled with abusive business practices. The result has been massive across-the-board changes in reimbursement policy and administrative record-keeping for our small segment of the health care industry. Yet, not only have these draconian measures failed to "balance the Medicare budget," but, in many cases, they have jeopardized access to needed care for Medicare beneficiaries across the country. Such documented cases, Mr. Chairman, are particularly prevalent in rural settings and states such as West Virginia.

NAMES strongly supports efforts to eliminate unethical practices in the Medicare program, generally, and the HME industry, specifically. Legitimate HME suppliers, who comprise most of the industry, have a common interest with policy makers, and that is to stop all unethical HME business practices. This goal can only be achieved, however, through a comprehensive and targeted approach that supports legitimate suppliers by strengthening the industry while also making it extremely tough on scam operators to conduct business.

For this reason, we hope that you will give serious consideration to incorporating into your efforts the comprehensive ethics legislation for the HME industry that NAMES helped develop and which was introduced as H.R. 2534 by Representative Ben Cardin (D–MD) last year. H.R. 2534 has elicited strong Congressional interest since its introduction in the House and currently has 108 co-sponsors. Several provisions of this bill have been incorporated into H.R. 3837, the "Federal Program Improvement Act of 1991," introduced by Rep. J.J. Pickle (D–TX). Similar legislation also has been introduced in the Senate in the form of S. 1736, the "Durable Medical Equipment Patient Protection Act of 1991," introduced by Senator Jim Sasser (D–TN) and S. 1988, the "Quality in Medical Equipment and Supplies Act of 1991," introduced by Senator William Cohen (R–ME). These bills, currently pending before this Committee, would strengthen the standards under which HME suppliers operate and also provide for other needed areas of reform.

NAMES recognizes the advantage of strengthening ethics in the HME industry through tightening current requirements for obtaining a Medicare Part B supplier number. As evidenced by the relative ease with which individuals intent on defrauding the Medicare system are able to operate their scam operations, the current system under which such numbers are issued to suppliers with little or no scrutiny of business practices or quality of care absolutely requires revision. However, my legislative modification to this administrative process must ensure that the reforms are effective, strong and capable of enforcement. Certain minimum criteria should be met by all individuals interested in becoming and remaining qualified as HME suppliers.

S. 1988 contains an extremely critical provision to HME suppliers and physicians alike. This provision is a prime example of why *targeted* legislation is needed to counteract prior attempts to address perceived abuses by punishing all HME suppliers, physicians and the beneficiaries they serve. Current Medicare law prohibits HME suppliers from completing any part of the claims processing document (called certificates of medical necessity or "CMNs") required by the Health Care Financing Administration (HCFA) to show that an item of HME is medically necessary.

By prohibiting suppliers from completing any portion of this document—which may involve extremely technical and verbose explanations detailing such issues as wheelchair seat height, width and elevating versus swing-away leg rests—physicians now will be required to become intimately knowledgeable about literally hundreds of minute HCPCS codes and other complex technical equipment-related data. This is complex, HME-specific data which physicians have neither the expertise nor the time to learn. When this provision is implemented fully by HCFA, the administrative slowdown in claims processing and the ultimate resulting delay in beneficiaries obtaining needed HME will be immense and certainly counterproductive to the intent of this Committee—namely to reduce waste, fraud and abuse, and streamline Medicare administrative operations.

For this reason, H.R. 2534 and S. 1988 are needed to correct this ill-conceived policy. Both bills target the CMN distribution prohibition where the need exists—on specific items of HME which the Secretary of Health and Human Services determines are subject to abuse or overutilization. It is this kind of appropriate policy rationale that we need to consider to reduce waste and fraud in the Medicare program—not the current mind set that embodies a philosophy of increasing paperwork and bureaucratic administrative burdens across-the-board rather than targeted to the abusive few.

Another important legislative provision for streamlining Medicare administration is the critical need for enactment of a first month, lump sum "purchase option" for certain item of HME. Where it is clear from the outset that the patient's need is permanent or long-term—either through physician diagnosis or other objective standards—a Medicare beneficiary should be entitled to purchase the equipment at the beginning, rather than incur additional needless administrative burdens on Medicare carriers through processing monthly rental claims. This critical provision, while contained in H.R. 2534, is not currently in any Senate bill. NAMES therefore urges you, as you consider other HME-related legislative initiatives, to amend S. 1988 to provide for such a purchase option.

As with any relatively young industry, I candidly acknowledge there have been problem with a small minority of HME suppliers who take advantage of existing loopholes in the Medicare program. Reports of certain abusive business practices by some unscrupulous people who have orchestrated so-called telemarketing operations or engaged in other "scam" practices under the guise of operating an HME company are known. At best, NAMES believes these unethical suppliers represent less than ½ of 1 percent of the HME services industry. Nonetheless, NAMES believes even one such supplier is too many, and for that reason, took the lead last year in developing sound corrective proposals for Congress' consideration. Since then, NAMES consistently has encouraged Congress to enact tough legislation to eliminate even those few individuals who not only damage an otherwise quality industry, but also cause unnecessary Federal expenditures and in so doing, exploit the elderly.

The HME suppliers represented by NAMES provide high-quality, 24 hours a day, 7 days a week, cost-effective home care services which allow people to recuperate from an illness or injury in their own homes surrounded by family and friends. HME allows individuals to enjoy independence with dignity and thus a better quality of life. As the spiraling costs of health care continue to fuel the national debate about how best to control expenditures while also providing quality care to Americans in need of these services, it makes sound economic sense to recognize the value of HME. Yes, HME outlays are growing. But the growth is, first of all, very modest compared to other segments of the health industry and is due almost entirely to expanding patient needs and the increasing demand for more medical care to be provided in the home rather than a more costly institutional setting—and not because of increased Medicare reimbursement levels which have actually decreased in the past 5 years.

Further, any hearing about Medicare waste should not focus solely on provider abuse. As you know, the Medicare program cannot operate efficiently without private contractors such as carriers. But when a carrier commits fraud or abuse, harm to the public can be as substantial, if not more so, than the harm incurred by any one particular health care provider. For example, the Department of Justice on April 17, 1992 announced its intervention in a lawsuit against a carrier, Florida Blue Cross and Blue Shield, alleging violations of the False Claims Act from 1986 to the present stemming from a scheme to defraud the Medicare program. The lawsuit contends that claims were mishandled and not processed as required by Medicare regulations. If Medicare does not have reliable data from its private contractors, how can it possibly go after the supplier community appropriately for potential infractions?

In addition, we do not even know what data the government maintains separate from these contractors in order to know whether the information the contractors are

maintaining is accurate. Carriers are paid millions of dollars to process claims accurately and timely. The criminal investigation in this lawsuit has been going on for two and one-half years without any culmination. Yet, HCFA continues to renew this carrier's Medicare contract and this carrier has been awarded new federal government contract responsibilities throughout this time period. Issues of this sort also must become part of both the focus of the health care fraud and abuse debate and of any ultimate solution.

In summary, NAMES joins you in your concerns relative to unethical practices and waste in the Medicare program. The HME industry is virtually unique in acknowledging problems in its sector and proposing thoughtful legislative solutions. We welcome hearings on such an important issue and the opportunity to discuss ways to eliminate such practices through mechanisms such as strengthening Medicare supplier number qualifications and imposing certification standards. NAMES strongly encourages you, however, to consider the total array of needed legislative changes for the HME industry and to enact legislation which addresses in a comprehensive fashion needed HME reforms such as a targeted CMN prohibition and a viable purchase option. We urge you also not to enact piecemeal or ad-hoc provisions which often punish legitimate suppliers while still providing enough "wiggle-room" to allow unscrupulous individuals to perpetuate their scams. To address the problem of abusive business practices in the HME industry, the proper response from Congress should be to target the abusers. To mindlessly reduce HME reimbursement across the board does nothing to punish abusers or extricate them from the program and it punishes the many for the sins of the few.

The HME industry is a valuable, increasingly vital element in our nation's health care system. In an era of increasing cost-consciousness and concern about the health care of our nation's elderly and people with disabilities, it makes plain policy sense to preserve the very benefit that provides health-related services in the most cost-effective and yet compassionate fashion. HME, as a part of home care, offers a practical alternative to the continuing high costs of institutionalization and allows for an enhanced quality of life. In fact, a May 1991 national survey conducted by National Research, Inc. shows that 75 percent of Americans would prefer to be taken care of at home if recuperating from a serious accident or illness. As our nation's elderly population increases and as further technological advances are made to help empower people with disabilities to realize their unique potential, policy makers should recognize HME as a unique contributor to our country's overall health care system.

In addition to legislative reform, NAMES also believes that a well-informed consumer is an equally important deterrent to Medicare "scam" operations. To that end, NAMES will continue its strong educational efforts for Medicare beneficiaries. As well, we are committed to help ensure that all NAMES member companies act ethically. NAMES will continue to take the lead in addressing unethical practices through education, cooperation with OIG and HCFA and, hopefully this year with your help, through passage of companion Senate and House bills which meet the needs of Medicare beneficiaries and the legitimate HME industry and the millions of Americans it employs and serves.

NAMES looks forward to working together with Congress to help solve these problems.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

I would like to thank Senator Jay Rockefeller, the Chairman of this Subcommittee, for holding this afternoon's hearing on fraud, waste, and abuse in the Medicare program. This costly, serious, and unfortunately all too pervasive problem is undermining Medicare, and I applaud your effort to focus needed attention on strategies for eliminating it.

Unchecked fraud, waste, and abuse in our health care system adds fuel to the fire of our health care crisis. Without counting waste, estimates of the losses due to fraud and abuse run as high as 10 percent of our nation's health care bill—about $80 billion this year alone. With respect to Medicare, this translates to over $10 billion in estimated losses.

Every member of Congress is wrestling with how to restore affordability and access to the system. No one has worked harder at resolving this question than you, Mr. Chairman. However, we cannot claim success in reforming our health care system until we have made successful inroads into controlling fraud and abuse that plagues this system.

Most health care providers are honest. However, even a small number of unscrupulous individuals can—and do—steal enormous amounts of money from Medicare.

At a hearing of the Special Committee on Aging I chaired last Fall, I heard the story of how a telephone salesman pushed unneeded and dangerous medical equipment on an elderly woman and then charged it to Medicare. Her continued appeals to Medicare to refuse payment and to force him to take back the equipment fell on deaf ears. She later learned that this same scam had been perpetrated in her state, and in neighboring states, and resulted in false billings to Medicare totalling $9 million. Unfortunately, there are too many similar stories across the country.

At that same hearing, a representative of the General Accounting Office testified, that Medicare beneficiaries are the primary source of leads on fraud and abuse, and yet about half of all their calls to Medicare are ignored. How did the representative of the Health Care Financing Administration respond to these findings? She announced that HCFA was closing down the toll-free lines beneficiaries used to make these calls. Fortunately, an uproar from Congress prevented this from happening.

With the Medicare bureaucracy asleep at the switch, fraudulent medical equipment suppliers have been able to steal an estimated $200 million yearly. After hearings and legislation resulting from the leadership of Senator Sasser, the Chairman of the Budget Committee, and Senator Cohen, the Ranking Minority Member of the Aging Committee, the bureaucracy is finally starting to wake up and take steps to deal with this problem. I am pleased to have supported these efforts.

Unfortunately, the failure to take health care fraud and abuse seriously is not limited to the Medicare bureaucracy. In my capacity as Chairman of the Federal Services Subcommittee, I've been trying for the last several years to get the Office of Personnel Management to implement anti-fraud controls in the area of federal employee health benefits. These controls were mandated by legislation in 1988, and to this day OPM has not taken action.

Mr. Chairman, crooked health care providers are running circles around Medicare, grabbing millions of dollars with each turn. When—and if—these crooks get caught they simply prey on another segment of our massive and fragmented health care system. It's high time the Administration showed leadership, rather than laxity, in efforts to stem this epidemic.

According to a GAO report that was issued about two weeks ago, a major reason crime pays in the health care industry is because of a lack of communication among federal agencies charged with fighting this problem. The Attorney General is not talking to the Secretary of the Department of Health and Human Services, the Inspector Generals are not talking with the Federal Bureau of Investigations, and Medicare and Medicaid bureaucracies aren't speaking. This situation is unacceptable.

Consistent with GAO's recommendation, I intend to soon introduce legislation that will not only get these federal agencies talking to one another, but require that they work together in this area. This legislation will set up a task force comprised of the Attorney General, the Secretary of HHS, and all of the other heads of federal and states agencies charged with combating health care fraud and abuse.

This will not be a permanent task force, and it will not cost the taxpayers any money. The task force's job will be to save millions if not billions of dollars by developing mechanism's for coordinating anti-fraud and abuse activities, finding ways to ensure that beneficiaries are enlisted in those activities, and advising the Congress of any changes that are needed in federal policies to help in this effort. Similar legislation was recently introduced in the House by Representative Ted Weiss, Chairman of the Government Operations Subcommittee on Human Resources and Intergovernmental Relations.

Mr. Chairman, I will conclude my statement by again thanking you for holding today's hearing. I urge you and others to support this legislation.

PREPARED STATEMENT OF SENATOR JIM SASSER

I want to commend the Committee and Senator Rockefeller and Senator Bentsen for holding this hearing. It is timely, it addresses a subject I believe needs immediate attention, and I hope this Committee will be able to move forward expeditiously on legislation to correct problems of fraud and abuse in Medicare's durable medical equipment and supply program.

I am glad to be able to present to you today the results of several hearings I chaired, as Chairman of the Budget Committee, and discuss with you the provisions of S. 1736, the Medicare Durable Medical Equipment Patient Protection Act of 1991. I note that Senator Grassley was also active in our Budget Committee hearings, and both Senator Grassley and Senator Pryor, along with several other members of the Senate, have sponsored this legislation.

Between May 13, 1991 and November 21, 1991 the Budget Committee held five hearings in Waste and Abuse in Medicare Payments for Medical Equipment and Supplies. I would like to submit a copy of those hearings, along with a preliminary staff report, for the record and summarize our major findings here.

MANIPULATION OF THE SYSTEM BY SOME UNSCRUPULOUS PROVIDERS

Testimony offered to the Budget Committee suggested widespread manipulation of Medicare reimbursement for medical equipment and supplies.

(1) We found many instances of "*carrier shopping.*" Suppliers would shop around for the highest reimbursement rates and the most lenient utilization allowances and arrange their business so as to bill carriers where they could get the highest profits—even though they were actually selling and delivering in areas with much lower costs.

This practice is encouraged by wide variations among Medicare carriers in allowable reimbursement and coverage policy. We found, for instance, that Medicare paid $42 for a wheelchair seat cushion pad in Tennessee—but a supplier could get $249 for the same pad in Pennsylvania.

(2) We uncovered one agent with a Medicare billing number who 'was also grossly inflating billings for ostomy supplies through "*unbundling*" of claims. He increased his profits, and the cost to Medicare, by 1,400 percent by buying $160 worth of invoices for ostomy supplies sold to a Medicare beneficiary by a local Tennessee equipment supplier—and then billing the Pennsylvania carrier for $2,300 component by component (rings, flange, paste, pouch). We also heard of entire wheelchairs being billed piece by piece.

(3) "*Parameter billing*" was another practice we found widespread. Some suppliers, once they had located a carrier with lenient utilization guidelines on a specific item, would then sell to Medicare beneficiaries and bill at the highest utilization level allowed by the carrier—without regard to patient need.

The worst example of that we came across was a scam involving a small item—a "wound care kit"—routinely sold to nursing homes as dressings for bed sores. One carrier at the time allowed a high use (3 kits a day per patient per wound site) and had a high reimbursement ($30 per kit). One witness testified that his former employer billed for 60,000 kits a month for a profit of over $1.2 million a *month* just on this one item.

(4) We took some unsettling testimony about *kickback arrangements* between local equipment suppliers or nursing homes and Medicare billing agents.

In one instance the agent, a company with a Medicare billing number, would buy invoices for supplies sold to Medicare patients locally, pay the actual provider his retail price plus a 25 percent add-on, and then bill Medicare directly with his own great markup.

In the nursing home situation, the agent would deliver a great volume of cheap supplies to a nursing home—wound care kits or "multi-podus splints"—*pay* the nursing home either a monthly fee or a per-patient amount for "warehousing" and "record keeping"—and then bill Medicare for the equipment using the beneficiary numbers of all the Medicare patients in the nursing home. The equipment gets dumped in the storeroom, the nursing home gets *paid* for a free load of supplies, and the billing agent gets big bucks from Medicare.

(5) I was surprised to find that just about anyone could obtain a *provider number* for medical equipment and supplies. There was no system to determine whether those billing Medicare for items sold to beneficiaries were bona-fide suppliers, virtually no questions were asked, and there was no limit to the number of different provider numbers one business could obtain.

One of the scam artists we focussed on in our hearings was doing business under at least five different names, possibly as many as ten. If billings under one number came under any scrutiny, he simply switched billing numbers.

Mr. Chairman, those are just some of the worst examples of the testimony we took during our hearings. We didn't even spend any time on other schemes which have gotten a lot of attention from other sources, such as telemarketing schemes and falsification of certificates of medical necessity.

MEDICARE DURABLE MEDICAL EQUIPMENT PATIENT PROTECTION ACT OF 1991

There clearly is room for major reform in Medicare payment policies in this area. Our bill, S. 1736, called for several changes to prevent, or at least make it harder, for these fraudulent activities to take place.

We called for more uniform reimbursement policies and greater claims screening by limiting the number of Medicare carriers handling this type of business to no

more than five. We also would eliminate carrier shopping by requiring so-called "zip code billing." Further, to combat a situation in which virtually anyone could receive a Medicare provider number—and in some cases, many numbers for one supplier—we called for a new provider number system with broad information disclosure and a regular provider number renewal process.

I have been pleased to note that the Administration has since taken some positive steps on these three fronts. After hearings, and after legislation was introduced, new regulations were proposed to consolidate the carrier structure for all medical equipment and supplies, to require "zip code billing," and to institute a new provider number application process.

These regulations are now in the process of being finalized, and I am hopeful that, once the new administrative system is in place, the Medicare program will be in a much better position to prevent fraud and abuse in this area. I would urge this Committee to closely monitor the implementation of these new rules to make sure they are fully implemented and that a coordinated system of claims monitoring is aggressively applied.

I would also note that, since our hearings, separate administrative steps have since been taken to eliminate the glaring loophole we found regarding reimbursement for the so-called "wound care kits."

Even with these positive steps, however, I would urge this Committee to consider additional legislative steps which I believe would make it easier for the new administrative structure to make a real difference. Our bill also addressed the following areas:

(1) *Mandating Uniform Pricing And Coverage Policy:* The large variations in reimbursement amounts and coverage and utilization policies for the same item from one carrier to another acted as an invitation to some unscrupulous providers to gouge the system. They also, in effect, have served to deny some Medicare beneficiaries the same benefits that others may receive. The differences may be somewhat less over time as the new carrier structure takes shape, but I believe this is a basic problem that needs further legislative action. The new carriers may still operate on more local determinations of allowable reimbursement and utilization, and from what I have seen there needs to be a complete re-evaluation of the whole pricing system for medical equipment and supplies.

I would urge the Committee to move toward uniform national pricing and coverage and utilization criteria for all equipment and supplies.

If you can't do it all at once, I would support a provision now being considered in the House to begin this process with about 200 selected items.

At a minimum, I would immediately put certain items we found to be subject to great abuse (ostomy and tracheostomy supplies, urologicals, surgical and other medical supplies) under a national fee schedule similar to that now applied to major medical equipment items. A very preliminary estimate of savings just on this one small provision of our bill alone is about $100 million over five years.

(2) *Making The New Administrative System Work:* While I have said I believe the steps taken by the Administration to streamline the carrier structure and set up new requirements for obtaining provider numbers is a step in the right direction, I have some concerns about it not making much difference unless adequate resources are devoted to claims screening, verification of supplier information, and monitoring of the new system in general.

Because of this concern our bill authorized the Secretary, through carriers, to charge suppliers a fee of up to $100 upon application for a billing number. These user fees could provide adequate funding for a strong enforcement system. We have been told by several supplier organizations that they would support this type of financing in the interests of guaranteeing closer scrutiny of the "bad apples" in the business. Since we introduced our bill, we have had some conversations with Administration representatives which suggests that the fee amount could be significantly smaller than $100, but I would urge the Committee to consider authorizing some version of this user fee to make sure that the new administrative system works as it should.

(3) *Additional Anti-Fraud Measures:* Mr. Chairman, I am convinced that plugging up the loopholes in the system that invite this kind of abuse will help, but that it may not be enough. To that end our bill also would require the Secretary to develop a list of suppliers who have abused the system in the past and authorize the carriers to require prior approval of billings submitted by those on the Secretary's list. This is modeled on the prior approval authority you have already enacted for certain equipment items subject to abuse.

Our bill also would strengthen the current law definition of what constitutes a kickback by making it clear that it includes arrangements between nursing homes

and suppliers which provide remuneration solely for "paperwork" (no more than turning over beneficiary assignment of rights and getting signatures on certificates of medical necessity if required) and "warehousing."

ADEQUATE FUNDING FOR MEDICARE PAYMENT SAFEGUARDS

Mr. Chairman, I would also like to briefly address the broader area of funding for payment safeguard activities performed by Medicare contractors and carriers. As you are well aware, the General Accounting Office and others have sounded alarms about what they see as underfunding of payment safeguard activities in general—and about problems in the Medicare Secondary Payor program in particular.

I have been aware of these problems both as Chairman of the Budget Committee and as a member of the Appropriations Committee, and the testimony we took from several people during our medical equipment hearings has only reinforced for me the necessity of adequate funding for these activities.

Over a year ago, my staff worked with the Appropriations Committee staff and with the Congressional Budget Office to see if we could find a solution to this problem under the current budget strictures. Our proposal at the time was that we appropriate some additional "seed" money for enhanced payment safeguard and payment recovery activities. The additional return in the form of program recoveries which everyone seems to believe would materialize from this activity could then be deposited in a revolving fund and the savings could be used to finance on-going payment safeguard activities. In this way we could make an additional investment in this activity which would in effect be self-funding except for the initial appropriation of "seed" money.

Our proposal did not carry the day then, but I believe something along these lines is still a viable option.

I know Senator Grassley has now made a proposal to adopt a recommendation made by the General Accounting Office to change the budgetary treatment of Medicare payment safeguard activities. The recommendation follows past precedent set for appropriations for IRS compliance spending, in which the law provides for discretionary spending limits to be increased if additional amounts above a specified base are appropriated for these compliance activities. I believe a similar approach is being considered in legislation being considered by the House Ways and Means Committee.

Mr. Chairman, I am sure you will appreciate the mixed feelings I might have about such an approach wearing my hat as Chairman of the Budget Committee.

On the positive side, I have already said that I agree we need to devote more resources to this activity. And the outcome of this new approach would appear to be much the same as the revolving fund idea we had earlier considered. In principle, I can support this recommendation.

My major policy concern here would be—with either a revolving fund or with a change in budgetary treatment—that there be specific, accountable, verifiable returns from increased program safeguard activities linked to any additional funding made available for that purpose. In other words, I would question an approach which would simply provide open-ended funding for all contractor and carrier operations.

On the down side, I am sure the Chairman, and Senator Grassley, will understand when I say I think we must be extremely cautious when talking about opening up the Budget Enforcement Act to amendment. I have not solicited opinion on this subject, but I am sure that there will be many people out there who can make just as strong a case for special budgetary treatment for other programs and activities.

PREPARED STATEMENT OF JANET L. SHIKLES

Mr. Chairman and Members of the Subcommittee: I am pleased to be here to discuss the challenges that the Medicare program faces in assuring that payments to medical providers are timely and accurate while minimizing the loss of funds through fraud, waste, and abuse. These challenges are hardly unique to Medicare: similar challenges face all health insurers.

Actions taken to combat Medicare fraud and abuse are known collectively as payment safeguard activities. Medicare generally devotes more resources to safeguard activities than do private sector companies. But several GAO studies over the past few years have shown that Medicare actions are still inadequate.

We released a report 2 weeks ago in which we discussed the enormous cost the nation incurs as a result of health insurance fraud and abuse.[1] Nobody knows for sure how much is lost, but many believe fraud and abuse account for some 10 per-

cent of all health care spending. In that report we called for a national commission to develop remedies, in part because of the inability of thousands of individual insurers to successfully address fraud and abuse independently.

A major impediment to detecting fraud and abuse in health care payments is the complexity of the health insurance system. Over 1,000 payers process 4 billion claims annually to pay hundreds of thousands of providers. Medicare itself expects to process 600 million claims for about 34 million beneficiaries. In the current health insurance environment, profiteers are able to stay ahead of those who pay claims for several reasons. These include the (1) independent operations of the various health insurers that limit collaborative efforts to confront fraudulent providers, (2) growing financial ties between health care facilities and the practitioners who control referrals to those facilities, and (3) costs associated with legal and administrative remedies to fraud and abuse. Finally, an insurer's efforts against unscrupulous providers can result in scams being shifted to other insurers.

Medicare not only is subject to many of the problems common to all payers, but also faces a challenge attributable to its complex administrative structure. The Health Care Financing Administration (HCFA), which oversees the program, operates through numerous contractors responsible for the daily tasks of claims processing and administration. This administrative network facilitates the handling of local needs and differences, but it can and has led to significant variations in administrative practices and payment policies among geographic areas. Finding the appropriate level of national uniformity while leaving enough discretion to handle local differences and foster innovative approaches to address fraud, waste, and abuse is a significant difficulty facing HCFA.

SPECIAL CHALLENGES FACING MEDICARE MANAGERS

In 1965, when the Medicare program was enacted, the law called for insurance companies—private insurers and Blue Cross and Blue Shield plans—to process and pay claims. This arrangement was pragmatic in that insurance companies had both claims-processing experience and an understanding of the medical practices of their communities. As a result, contractors were given considerable discretion in setting and implementing payment and safeguard policies. Much of this latitude is retained to this day.

The efficient management of the Medicare program therefore depends on how well the contractors perform their jobs and in turn on how well HCFA oversees contractor performance. This administrative arrangement has its advantages and its disadvantages. One advantage is that contractors have the flexibility to develop effective claims-processing systems and medical review policies supported by aggressive payment safeguard activities. A disadvantage is that HCFA's ability to manage a consistent, national program is limited by the variation in contractors' interpretation of Medicare rules and regulations. In providing direction to its contractors, HCFA must maintain a balance between, on the one hand, developing national program policies and operations that protect program funds, and on the other, preserving the autonomy of contractors to run their own operations and that of providers to make decisions about rendering medical services.

HCFA has sought to maintain this balance by gradually moving toward fewer contractors over the years and by adopting more uniform data-processing systems that should permit greater uniformity in contractor payment-processing and safeguard activities. This will also facilitate more rapid and consistent implementation of HCFA contractor directives and other program changes.

Despite these initiatives, we and others have identified recent problems in program operations. These suggest that HCFA may need to increase oversight of its contractors and that, working together with the Congress, HCFA needs to seek to attain adequate and stable funding for program safeguard activities.

PROGRAM WEAKNESSES SUGGEST NEED FOR STRONGER HCFA OVERSIGHT ROLE

Let me cite some of the problems we have identified in our audit work that illustrate oversight weaknesses. These include investigation of fraud and abuse allegations, recovery of hospital overpayments, control over who can bill the program, and payment methods for emerging technologies.

Contractors' Complaint Investigations and Overpayment Recovery Efforts

We recently reported on two areas where limited HCFA oversight of Medicare contractors contributed to a breakdown in program protections. The areas involved the investigation and referral of beneficiary complaints and the recovery of overpayments to hospitals. We found that contractors did not adequately investigate bene-

ficiary complaints or recover credit balances owed to Medicare and that HCFA's contractor monitoring systems did not identify these performance problems.

HCFA provided virtually no program guidance to Medicare contractors regarding the investigation of beneficiary complaints—a primary source of fraud, waste, and abuse leads. In fiscal year 1990, Medicare contractors reported receiving about 18 million calls from program beneficiaries. A small but significant portion of the complaints we monitored at five contractors were allegations of fraud and abuse. Half the beneficiary complaints alleging fraud and abuse were not referred to carrier investigative staff. Moreover, many complaints that were properly referred were not adequately investigated.[2]

Carriers' failure to adequately investigate beneficiary complaints of provider fraud and abuse can result in missed opportunities to recover overpayments, impose penalties, and send a message to the provider community that fraudulent or abusive behavior will not be tolerated. The potential of effective investigation and referral is illustrated by one case in which a provider was initially pursued for billing irregularities for eye care services because of beneficiary complaints. Upon further investigation of over 100 apparently similar complaints, about 300 fraudulent claims were detected. The provider involved agreed to refund over $2.5 million to the federal government.

We also found that HCFA was not giving adequate program guidance to contractors regarding the recovery of hospital overpayments.[3] The refundable amounts, referred to by hospitals as credit balances, typically occurred both when Medicare and other insurers mistakenly paid for the same service or when Medicare paid twice for the same service. Many of the hospitals' credit balances had been outstanding for several years, despite attempts by some to repay the money. The contractors we visited were doing little to identify amounts owed Medicare or to assure that refunds were promptly recovered. In response to a special HCFA survey of providers, over 9,000 Medicare hospitals and other providers reported $171.7 million in overpayments, of which $84.2 million had been repaid as of March 1992. HCFA plans to implement a reporting and tracking system to monitor such overpayments and assure they are promptly recovered.

Controls Over Who Can Bill Medicare

The absence of a strong HCFA role has also contributed to contractors' weak controls over who can bill the program, how to issue and when to retract provider numbers, and when to update information on providers. Under the procedures of many contractors, providers applying for billing numbers receive little scrutiny of their qualifications or their ownership or investment relationships. For certain provider types, contractors have difficulty identifying whether an applicant has been previously disciplined by the program, has existing Medicare debts, or has the financial wherewithal to maintain solvent business operations. In addition, a single provider can obtain multiple numbers. The Department of Health and Human Services (HHS) Office of the Inspector General reports that many Medicare contractors cannot identify or deactivate numbers for providers who have lost the legal authority to practice.[4] HCFA has proposed regulations and guidance to obtain ownership information, establish minimum standards for some suppliers, and improve contractor control over provider numbers.

We will soon report on how limited controls over provider numbers were an integral part of a multimillion-dollar fraud scheme involving mobile physiology labs.[5] The fraudulent billings were masked behind at least 30 different corporate names and Medicare provider numbers. The multiple numbers greatly complicated carriers' efforts to detect suspiciously high volumes of tests. In 1987 Medicare successfully prosecuted laboratory operators involved in the scheme, and one owner was imprisoned. However, Medicare's efforts to recover overpayments to providers affiliated with the scheme have not been successful, and at least $5 million has not been recovered.

Payment Methods for Emerging Technologies

Establishing payment methods for emerging technologies is another area where HFCA oversight needs improvement. Medicare's reimbursement for magnetic resonance imaging (MRI) is a case in point. HCFA established only broad guidelines for setting payments for MRI services when these were first covered in 1985. As a result, the carriers established a wide range of MRI reimbursement rates. In some localities, Medicare's payments for MRI did not reflect the lower costs per scan that efficiency and economies of scale have achieved. In these locations, Medicare's payment rates encouraged a proliferation of machines because they even permitted providers with high-cost, low-volume machines to profit from scans charged to the pro-

gram. Despite recent changes in standardizing Medicare's payment for MRS services, HCFA did not fully adjust such payments to reflect declining costs.

Essentially, Medicare payment rates for new technologies are not systematically adjusted as the technology matures and unit costs decline. Failing to make such adjustments results in unnecessarily high Medicare payments and encourages an oversupply of the equipment because profits can be earned at inefficient levels of operation.[6]

BUDGET CUTS UNDERMINE ACTIVITIES TO PREVENT FRAUD, WASTE, AND ABUSE

Many of the problems we have discussed above may be attributable to budget cutbacks that have affected program administration. Though Medicare's payment safeguard activities are cost-effective—returning nearly $11 for every dollar spent in 1989—contractor budgets to perform these functions were cut from 1989 through 1992. During this period claims volume rose by about 40 percent; however, Medicare cut its contractors' funding for payment safeguards by $15 million.

Cuts in payment safeguard areas translate into increased program losses from fraud, waste, and abuse. The largest portion of contractor safeguard funding pays for staff who perform claims reviews, investigate providers suspected of fraud or abuse, and conduct financial audits of institutions to assure the accuracy of Medicare cost-based payments. Thus, if claims volume increases while the numbers of safeguard staff remain constant or decline, contractors review a lower percentage of claims.

Funding reductions have resulted in contractors cutting back on medical and utilization reviews of claims that are essential in detecting and preventing erroneous payments. Contractors also attribute inadequate funding as the reason for not pursuing hundreds of millions of dollars owed to Medicare by private insurers whose payment responsibility was primary to Medicare's and for fewer and less timely audits of the billions of dollars claimed by hospitals and other institutional providers.

The magnitude of the potential losses incurred by Medicare as a result of these cutbacks is illustrated in our reports on Medicare's secondary payer program. In 1990 and 1991, we found a large inventory of potential mistaken Medicare payments that were not being investigated. When HCFA implemented a system in mid-1991 to track this inventory, contractors reported over $1.1 billion in unrecovered claims that were mistakenly paid. At the same time, the contractors reported not having investigated an additional large backlog of claims to determine what amounts Medicare paid that primary insurers should have paid. We estimate that once these additional claims are investigated, over $1 billion in mistaken payments could be owed by primary insurers.[7]

Contractors were doing little to recover these claims, at least in part because their funding for these activities was significantly reduced in fiscal year 1990 and remained at that level in fiscal year 1991. As of December 1991, about 80 percent of these claims remained unrecovered. In response to this problem, contractors were provided an additional $20 million during fiscal year 1992 to recover monies due Medicare.

In its fiscal year 1993 budget, HHS proposed increases in Medicare's payment safeguards budget. The planned increases in contractor safeguard funding, if appropriated, will allow contractors to replace staff lost to cutbacks in prior years and to accommodate the growing claims workload. It will take some time, however, to hire and train the necessary staff and to implement expanded safeguard programs.

In today's difficult budget environment, the stability of Medicare contractor funding levels will remain in question. Consequently, we continue to believe that the Congress should consider modifying the budget process to better assure adequate and stable Medicare contractor funding.[8]

CONCLUSIONS

In conclusion, fraud, waste, and abuse contribute unnecessarily to the health care cost spiral that confronts this nation. Like most insurers, Medicare faces program losses because of inefficiency and exploitation. These expenditures are particularly troublesome in light of the current budgetary environment and increasing beneficiary out-of-pocket costs. HCFA generally places more emphasis on program safeguards than private insurers. Yet, while HCFA has generally reacted to remedy identified weaknesses, the program remains vulnerable to unwarranted losses.

In particular, Medicare administrators face unique barriers to running a consistent, equitable national program. Policymakers need to act to ensure that contractors have clear incentives to manage program dollars efficiently and effectively. One aspect of this issue is consistent funding for such activities. Contractors need some assurance that funding for safeguard activities will be stable and adequate so that

they can hire and train necessary staff. Such funding would provide the incentive necessary for contractors to make a long-term commitment to improving safeguard activities.

Funding levels for these activities, however, have not been stable, especially when viewed in light of increased claims volume. Moreover, recent program changes have required additional resources from contractors. Not surprisingly, contractors report that safeguard activities have been adversely affected. Consequently, we continue to support modifying the Budget Enforcement Act to enable adequate and stable funding for Medicare program administration.

In our view, HCFA must also take a more active stance to hold contractors accountable for their performance in program administration. To monitor and direct contractor actions, HCFA may need to develop better information systems, more focused performance measures, and stronger contractor guidance.

I want to thank you for the opportunity to speak before you today. This Committee's interest and involvement in HCFA's administration of Medicare is likely to be an important component in addressing the major challenges faced by the agency.

ENDNOTES

1. *Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse* (GAO/HRD–92–69, May 7, 1992). Testimony on same topic (GAO/T–HRD–92–29, May 7, 1992).

2. *Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse* (GAO/HRD–92–1, Oct. 2, 1991). Testimony on same topic (GAO/T--HRD–92–2, Oct. 2, 1991).

3. *Medicare: Millions of Dollars in Mistaken Payments Not Recovered* (GAO/HRD–92–26, Oct. 21, 1991).

4. *Carrier Maintenance of Medicare Provider Numbers,* Department of Health and Human Services, Office of Inspector General (OEI–06–89–00870, May 1991).

5. *Medicare: One Scheme Illustrates Vulnerabilities to Fraud* (GAO/HRD–92–76, forthcoming).

6. *Medicare: Excessive Payments Support the Proliferation of Costly Technology* (GAO/HRD–92–59, forthcoming).

7. *Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers* (GAO/HRD–92–52, Feb. 21, 1992).

8. Under the Budget Enforcement Act of 1990, the Congress provided for increasing appropriations for IRS compliance activities without necessitating spending cuts elsewhere. We recommended using IRS' method of funding compliance activities as a potential model. See *Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs* (GAO/HRD–91–67, May 15, 1991).

Prepared Statement of George E. Spalding

INTRODUCTION

I am Dr. George Spalding, the Medicare Medical Director for Transamerica Occidental Life, the Part B Carrier for Southern California. I have held this position since April 1990. I am a board-certified surgeon, specializing in cardiovascular surgery, and have spent 36 years in private practice. I have been asked to discuss the role of carrier medical directors, the so-called "hassle factor," the detection of fraud and abuse, and the role of the Peer Review Organization (PRO).

THE ROLE OF THE CARRIER MEDICAL DIRECTOR

In 1988, discussions between the American Medical Association (AMA) and the Administrator of the Health Care Financing Administration (HCFA) resulted in the requirement that all Part B carriers employ a full-time medical director.

Since that time, the duties of the medical director have evolved to include serving as a source of medical information, interfacing with medical societies and peer groups, assessing current health care trends and technologies, and the developing of local and national policy issues under HCFAs direction. In addition, the medical director takes a leading role in determining when medical guidelines must be developed or revised, and defending medical guidelines when challenged.

THE "HASSLE FACTOR"

Whenever I am in the presence of other physicians, talk invariably turns to the so called "hassle factor." The list of perceived hassles is endless:

- there is too much paperwork
- the rules change unnecessarily
- too much documentation is requested
- Medicare tries to tell physicians how to practice medicine

One of the most frequently mentioned hassles is the use of prepayment screens. These screens flag a claim for manual review when it exceeds a numerical parameter. Services that exceed those parameters were either developed for additional information, reduced to a lower level of care, or denied. In reaction to provider complaints, HCFA is now moving toward focusing medical review upon those providers whose services clearly vary from their peers.

DETECTION OF FRAUD AND ABUSE THROUGH FOCUSED MEDICAL REVIEW

Carrier medical review is an efficient means of generating a savings to the Medicare program.

Historically, Transamerica Occidental's Medicare Division has relied on a number of internal computer reports to detect outlier physicians and suppliers. While these reports give us high levels of insight into patterns of practice, they lack the breadth of information that national data supply

Very recently, HCFA has released focused medical information for carrier use, based upon an analysis of 1998 and 1991 claims data. This data shows the top 30 services billed by all carrier providers, as well as the top 30 services for each medical specialty group. A national ranking is provided for the same services. For example, if a medical procedure was ranked 5th in a carrier but 30th nationally, the carrier would want to examine why its providers in a particular specialty performed it proportionately more often that their national peers. We are hopeful that HCFA will continue to provide carriers with tools like this data.

In our own area, we have identified several outlier physicians and are requiring special claims submission procedures focused only on their aberrant practices. One aberrant practice that came to light showed that some cardiologists were performing combined right and left cardiac catheterizations at a rate of about 3 times that of other cardiologists. Catheterizing both the left and the right side of the heart pays more than when only the left side is done. Clear medical indications for catheterizing both sides of the heart have been established and published. It has been established that approximately a 20% combined right and left catheterization incidence is the norm.

When we notice proportionately higher utilization, our practice as a carrier is to investigate further. In these cases, medical documentation was obtained only from those cardiologists with a nearly 50% incidence of combined right and left catheterization. Hence, not all cardiologists were "hassled" for additional documentation.

Our recent efforts in focused medical review have included an analysis of the interpretation of electronically transmitted EKGs. Section 4109 of Public Law 101–508 provides that, effective January 1, 1992, separate payment can no longer be made for EKGs that are performed or ordered as a part of a visit or consultation. Because electronically transmitted EKGs were exempted from this provision, we believed that there was a potential for abuse. I am pleased to report that there was no significant increase in paid claims for this service in the first quarter of 1992 over 1991. Not all reviews result in the identification of aberrant behavior, however, analysis of potential abuse is prudent even in the absence of significant negative findings.

Our efforts in focusing medical review have netted substantial savings to the taxpayer. In fiscal year 1991, Transamerica Occidental's Medicare Division realized $5.2 million savings from physicians and suppliers who defrauded or abused the Medicare program. This figure represents only our postpayment medical review savings.

An additional savings of $65.3 million was made due to our prepayment medical review screens. Focused medical review can direct carriers to the most appropriate avenue to pursue: i.e., prepayment screens and/or postpayment audits, which eliminates the need to request documentation from a large number of physicians.

THE ROLE OF THE PROS

Medicare carrier's are better equipped to perform the medical review for Part B.

The Peer Review Organizations (PROs) perform contracted utilization and medical review functions for the fiscal intermediaries who administer Part A of the Medicare program. They also perform limited Part B utilization review.

For a variety of reasons, we believe that the Part B Medicare carriers have an advantage over the PROs in conducting medical review. Most importantly, carriers see the entire universe of claims data, instead of the limited segment that the PROs

review. The PROs deal primarily with quality issues, while the carriers deal with both quality and quantity issues. The PRO/carrier exchange of medical review criteria program, now in effect, seems a clear example of duplication. The premise of this exchange is that medical review criteria can be brought into alignment between PROs and carriers. However, the information that we receive from the PROs is generally already known to us and does not assist us.

The cost of medical review and the timeliness of claims payment are other reasons we believe medical review should remain with the carriers. As carriers, we do not believe that the claims processing timeliness standards could be met if the PRO conducted prepayment review on such a significant volume of claims. When carriers conduct prepayment review on a claim, they have all the historical data related to the beneficiary available. This gives us a more rational insight into determining the necessity of the services rendered. PROs, on the other hand, look at the claim in isolation. We think that the carrier is better equipped to make a determination on the appropriateness of care. The additional data that the carrier has access to allows us to manage the review process efficiently.

CONCLUSIONS

In my role as a medical director, I am directly involved with our Program Integrity unit in the monitoring of fraud and abuse. Our approach to detect fraud and abuse is an interdepartmental effort, relying on prepayment Medical Review staff, postpayment Program Integrity staff and the insights and expertise of staff consultants in every major specialty of medicine. In addition, we utilize the expertise of many medical and surgical consultants, and meet frequently with specialty and subspecialty medical societies.

My work as a Medicare medical director for Transamerica Occidental has been the most challenging of my career. It is a privilege to be in a position in which I have the ability to influence both the proper expenditure of the taxpayers dollars entrusted to my carrier and the quality of the care rendered. I consider this a serious responsibility.

In order to accomplish our goals, we must continue to refine our medical review processes. We believe that medical review is best accomplished by a joint effort of prepayment and postpayment review. To perform one without the other is like clapping with only one hand.

An ongoing exchange of ideas between carrier's staff and medical directors is vital to achieving complementary policy across regions. Carrier medical review is an efficient means of generating a savings to the Medicare program. At Transamerica, for every administrative dollar spent, we save $12 in benefit dollars. Continued funding of medical review is crucial to the programs's success.

PREPARED STATEMENT OF WILLIAM TOBY, JR.

Mr. Chairman and members of the subcommittee: I am pleased to be here today to discuss our efforts to safeguard the Medicare trust funds from improper payments for services and supplies. The Medicare program actively pursues specific activities to ensure proper payment for necessary services. Today, I would like to focus on two major areas.

The Department's initiative to ensure proper payment for durable medical equipment is well underway. The DME initiative is aimed at curbing fraudulent and abusive activities, while setting more reasonable and appropriate payment levels for DME supplies nationally.

The Health Care Financing Administration is also committed to protecting the fiscal integrity of the Medicare trust funds by avoiding incorrect payments or recouping funds that were paid inadvertently. Every dollar spent on these payment safeguard activities is a good investment. In fact, we expect each dollar in the Medicare contractor budget devoted to payment safeguard activities will yield a $15 return to the trust funds in fiscal year 1993.

DURABLE MEDICAL EQUIPMENT INITIATIVE

Last November, the Secretary announced the Department's initiative to address fraud and abuse of DME and other medical supplies. While the vast majority of the DME industry operates fairly and honestly, the system has allowed some to engage in deceptive practices.

The reforms that Senator Sasser has put forward, as well as other legislation that has been introduced, will act as effective deterrents against fraud and abuse. However, many of these reforms are already being addressed as part of the Depart-

ment's DME initiative. The Department's DME initiative comprises a comprehensive program of regulatory, administrative and legislative improvements.

Regulatory Initiatives

Our final regulation addresses problems associated with claims processing, "carrier shopping" and billing numbers. The final regulation will be published at the end of this month.

Regional Carriers.—The final rule will reduce the number of carriers processing DME claims from 33 to four regional carriers. With fewer carriers, we will be able to utilize experienced personnel who can process claims more quickly and accurately. A smaller number of specialized regional carriers will reduce variation in coverage decisions. Also, four carriers can more easily cross check claims for possible fraud.

We are moving ahead with this initiative and are pleased to announce that we issued a Request for Proposals last week and hope to award contracts to four new regional carriers this October.

Carrier Shopping.—The regulation will prevent medical suppliers from "carrier shopping." Carrier shopping is the costly practice of shopping for carriers that pay the highest rate for particular equipment or supplies. Medicare will no longer pay for DME based on where the order was taken. Suppliers now will be paid based on the rate set where the beneficiary resides. The loophole that makes it easy for suppliers to game the system through carrier shopping will be closed.

Supplier Numbers.—The final regulation will also establish tight control over the issuing of supplier numbers. A Medicare billing number will not be issued until a supplier completes an application detailing information on ownership and business practices. The information collected on the application will be compiled in a national data base that will enable us to identify abusive suppliers and track them if they move a fraudulent business to a new location.

Minimum Standards.—Suppliers will also be required to certify that information on their application is true and that they meet basic, minimum operational standards. If compliance with the standards is not maintained, the provider number will be revoked.

Administrative Initiatives

Administratively, we are aggressively pursuing a number of activities that will curb abusive DME market behavior. Some of these administrative actions include:

- Creating model coverage and medical review guidelines for the 100 items identified as the most frequently used or abused;
- Developing standard requirements for certificate of medical necessity forms;
- Refining and standardizing the coding for all medical equipment and supplies;
- Developing improved carrier edits to prevent unbundling and separate billing of supplies for higher payment;
- Educating physician groups on the costs of medical equipment and the abusive practices of some suppliers; and
- Educating beneficiaries about supplier schemes to entice them to purchase equipment.

Legislative Initiatives

The Department's DME initiative also includes several legislative strategies that address both payment and administrative shortfalls. Our legislative proposals are aimed at establishing more reasonable payment amounts for DME items and other medical supplies and reducing incentives for fraud and abuse.

Prior Authorization.—Our prior authorization proposal would give carriers the authority to target either individual suppliers who exhibit abusive behavior or selected items that have been subject to abuse.

Certificates of Medical Necessity.—We propose extending the prohibition of supplier completion of certificates of medical necessity forms beyond DME to all items for which certification is required.

Adjustment of Fee Schedules.—One legislative proposal would improve the carriers' ability to use their "inherent reasonableness" authority to adjust payments that are either grossly excessive or deficient.

Enteral and Parental Equipment.—We also propose to pay for enteral and parenteral nutrients and supplies on the basis of a fee schedule and for enteral and parenteral equipment using the same methodology that is used for DME.

Enteral and parenteral nutrients and supplies are currently paid on a reasonable charge basis. Our research has shown that the Medicare program is paying too much. Under this proposal, we will establish a fee schedule based on wholesale and

retail price information. The proposed fee schedule will make payments more uniform and equitable. Projected savings in FY 1993 are estimated at $10 million.

Competitive Bidding.—We propose phasing in the use of a competitive bidding process initially for oxygen and oxygen products. An Office of Inspector General report found that Medicare's fee schedule for oxygen is, on average, 174 percent higher than the Department of Veterans Affairs. The DVA uses a competitive bidding process.

In addition, with fewer suppliers, we will be able to more closely monitor the quality of oxygen services provided to beneficiaries. Competitive bidding for oxygen would save $5 million in FY 1993.

Recategorizing Nebulizers and Aspirators.—We are proposing to eliminate nebulizers and aspirators from the "frequent servicing" category of Medicare DME payment.

Currently, we are required to make indefinite rental payments for nebulizers and aspirators based on the notion that they require frequent monitoring. These items, however, do not require frequent servicing, and Medicare rental payments often equal an amount that is many times the purchase price. Under this proposal, Medicare would save $30 million in FY 1993.

Payment Adjustments.—Finally, the President's budget includes a legislative proposal that would authorize the Secretary to make payment adjustments for DME, prosthetics, and orthotics, after taking into consideration market factors and technological changes. This proposal would save $20 million in FY 1993.

We believe these reforms would significantly curb DME fraud and abuse and standardize DME payments nationally. We look forward to our continued work with you and other members of Congress to put the system on the right track.

CONTRACTOR PAYMENT SAFEGUARD ACTIVITIES

From a broader perspective, Medicare is aggressively moving to combat incorrect and unnecessary payments. Medicare contractors serve as our frontline defense to protect the integrity of the trust funds. Contractors carry out four ongoing payment safeguard functions: medical and utilization review, provider audits; fraud and abuse detection and reporting, and the Medicare secondary payer program.

The Administration is committed to properly funding contractor payment safeguard activities while improving the efficiency of contractor performance. However, the payment safeguard function is one among many statutorily-prescribed demands, including processing and paying claims within the mandated timeliness requirements. Even within tight budget constraints, the President's FY 1993 budget request of $404 million for contractor payment safeguard activities is nearly 18 percent above the FY 1992 budget.

Over the years, contractor payment safeguard activities have yielded a healthy return for money invested. In FY 1993, Medicare contractors, both fiscal intermediaries and carriers, are expected to save the trust funds $6.2 billion in incorrect or unnecessary payments.

Medical Review/Utilization Review.—One of the major functions of payment safeguards is to determine that services billed are medically necessary and appropriate. Last year, Medicare contractors denied nearly 28 million claims, 4.6 percent of bills received, for services considered medically unnecessary or not covered under the Medicare program. HCFA is restructuring many of its utilization review policies to make more efficient use of limited contractor dollars, while at the same time minimizing the hassle inherent in the utilization review activities.

HCFA is committed to making utilization review more educational and, although we will still be denying claims, we hope to educate providers about appropriate services that are covered by Medicare. We are doing this by beginning to focus on paid claims data rather than on a claim-by-claim review. These data will be shared with providers so they can see how their practice pattern varies from that of their peers.

In addition, HCFA has taken a number of actions in the last year to detect the provision of unnecessary services or other inappropriate billing. We have developed computerized edits to detect abusive billing practices such as code unbundling and upcoding. In the first three months of 1992, these edits have saved almost $14 million.

We have also established the unique physician identification number (UPIN) system. The UPIN is a unique identifier for physicians who bill Medicare and is required on all claims for services ordered or referred. As a result of this system, we are now able to detect abuses resulting from inappropriate ordering and referring of services by physicians. In addition, since January 1, HCFA has been denying services referred by physicians to laboratories in which they have an ownership interest.

The FY 1993 budget request of $148 million for medical and utilization review is expected to yield a savings of $1.1 billion.

Fraud and Abuse.—The Department is expanding its efforts to detect fraud and abuse significantly in FY 1993. The budget specifically earmarks $24 million for fraud and abuse detection, more than double the current amount spent on this activity. We believe that earmarking funds specifically for fraud and abuse detection elevates the importance of this activity and invigorates the process. We expect these expanded fraud and abuse efforts to save $360 million in FY 1993. With this increased funding, we expect to substantially increase our referrals to the OIG for suspected fraud and abuse.

Contractors use a variety of information to detect and investigate fraud and abuse. For instance, Medicare beneficiaries often inquire about questionable billings and payments on their Explanation of Medicare Benefits. The EOMB is sent to beneficiaries and details the date and type of service that was received, the provider who billed for the service, and the amount billed. We have recently revised the EOMB form to make it easier for beneficiaries to understand and to identify incorrect Medicare payments for services.

HCFA requires carriers to begin investigation as soon as possible following receipt of a complaint or identification of a case of potential fraud or abuse. If there is substantial evidence of possible fraud and abuse, the carrier refers the case to the OIG for full-scale investigation.

In February 1992, we issued expanded fraud and abuse instructions to our contractors. Carriers will be required to establish full-time, Medicare-dedicated Fraud and Abuse Units. Contractors will also launch a major initiative to improve beneficiary understanding of health care services, equipment, and supplies so that they can help us better detect fraud and abuse.

Provider Audits.—A third major payment safeguard area is that of auditing cost reports for hospitals, home health agencies, skilled nursing facilities, and other Part A providers who are paid partially or completely on the basis of cost. In performing the audit, contractor staff examine the reasonableness of the costs incurred by the provider and disallows costs that are unreasonable or not related to the Medicare program.

In 1991, Medicare contractors audited 5,000 cost reports, and in doing so, disallowed $1.7 billion. As with other payment safeguard activities, we are working intensively to make the process more efficient by using more automation and concentrating on internal reviews to target audits at providers most likely to have claimed costs inappropriately.

The FY 1993 budget request calls for $150 million for provider audits. We expect to save $1.8 billion in 1993 for a return ratio of 12:1.

Medicare Secondary Payer.—The final payment safeguard function is the Medicare secondary payer program. The Medicare program, by law, cannot pay for services in certain situations when beneficiaries are covered by other insurance plans. Our contractors are responsible for identifying these situations.

Medicare pays secondary to an employer group health plan for elderly beneficiaries, for certain disabled beneficiaries, and for beneficiaries during the first 18 months of Medicare entitlement because of end-stage renal disease. Medicare is also secondary payer to workmen's compensation and to automobile, liability, and no-fault insurance.

In 1987, HCFA moved from a pay-and-chase mode in MSP when it initiated a first-claim development program. Initial claim development allows us to identify MSP cases before payment is made. Beneficiaries provide information about potential primary insurance coverage when their first Medicare claim is filed. Hospitals and other providers are also required, by their Medicare provider agreements, to ascertain primary health insurance information from beneficiaries.

The President's budget includes $82 million for MSP activities. We expect a return on investment of 58:1 for Medicare Part A and 18:1 for Part B, with an expected total savings of approximately $3 billion in 1993.

Although all contractor payment safeguard activities yield good returns, the MSP program has proven to be the most cost-effective way to secure Medicare funds from incorrect spending. Our MSP efforts are being enhanced by the effective implementation of the IRS/SSA/HCFA data match project, which was enacted in OBRA 1989 and extended by OBRA 1990. The data match assists us in identifying MSP cases, especially those resulting from spouses with health overage through employment.

The first cycle of the data match is completed. Using a screening questionnaire, we narrowed the nearly one million employers who might provide primary coverage to 700,000. We are currently receiving information back from employers on the availability of health care coverage for specific beneficiaries. We estimate recoveries

from the data match to be upwards of $600 million. We will begin the first recoveries next month.

Expanding the Common Working File

Central to our efforts to protect the Medicare trust funds more effectively in recent years is the development and implementation of the common working file. The common working file is a national, unified system of Medicare beneficiary entitlement and utilization data. The common working file, which is updated on a daily basis, allows us to coordinate Medicare benefits and to do prepayment review of claims.

The common working file will allow us to focus postpayment review on practitioners and suppliers who appear to be billing fraudulently or are misrepresenting the services or items being furnished to beneficiaries. In addition, information derived from the MSP data match will be entered into the common working file to enable contractors to identify MSP situations prior to paying claims.

FISCAL YEAR 1993 CONTRACTOR BUDGET PROPOSALS

In FY 1993, Medicare contractors will process over 730 million Medicare claims, respond to 37 million written and telephone inquiries, and perform 8.9 million hearings and appeals. In total, the President's FY 1993 budget request for Medicare contractors is $1,664 million. The budget request assumes enactment of four legislative proposals that would save over $89 million.

Incentives for Electronic Claims.—The President's budget proposes to pay claims submitted electronically faster than paper claims. Currently, Medicare pays both electronic and paper claims within 17 days. This proposal would allow electronic claims to be paid within 14 days. Paper claims would be paid in 27 days.

This proposal goes hand-in-hand with the President's health care reform plan advocating reductions in Medicare administrative costs. Claims submitted electronically could save Medicare nearly 50 cents per claim over paper submission. Because electronic claims are less costly to administer, this proposal would save $65 million in contractor funds in FY 1993.

Reassigning Fiscal Intermediary Functions.—Another legislative proposal in the President's budget would allow the Secretary to reassign fiscal intermediary functions from a substandard performer to another fiscal intermediary. This proposal would improve contractor efficiency and would save $3 million.

Elimination of Carrier Bonus Payments.—A third proposal would save $8 million by eliminating reward payments to contractors, over and above their cost reimbursement, for increasing participating physicians. While the number of physicians. participating in the Medicare continues grow, we have found no direct link between carrier reward payments and specific carrier action.

Caps on High-Cost Contractors.—The fourth legislative proposal would save over $13 million by capping contractor cost reimbursements at the 60th percentile of the actual unit cost of all contractors.

Enactment of these four legislative proposals would give us the firm authority and funding to creatively respond to the rapidly increasing costs of processing claims.

CONCLUSION

We believe we have a strong program in place for protecting the Medicare trust funds from inappropriate and unnecessary payments. The combined administrative and regulatory activities of the Department's DME initiative will go far toward ensuring more reasonable and appropriate payment amounts and deterring fraud and abuse. We are also working to improve the efficiency and effectiveness of contractor payment safeguard activities.

We recognize that improvements can always be made. Our legislative initiatives for DME and contractor changes would aid our efforts. We look forward to working with you in the future.

RESPONSES OF MR. TOBY TO QUESTIONS SUBMITTED BY SENATOR BENTSEN

Question No. 1. The General Accounting Office reported in a recent study that more than $2 Billion of erroneous Medicare payments had been made for claims where Medicare should have been the secondary payer. Specifically, The GAO cited a HCFA tracking system for Medicare contractors that showed a backlog in 1991 of $1.1 Billion of these claims that had already been paid. In addition, the contractors reported that they had not even investigated an additional large backlog of payments for which Medicare could have been mistakenly billed as the primary payer. GAO estimated that at least $1 Billion in mistaken payments could be owed by primary insurers, in addition to the $1.1 Billion backlog that is known.

In view of these backlogs reported by GAO, it seems that more money should have been spent in the last few years for Medicare payment safeguards relating to the secondary payment program. Yet at the hearing when Senator Durenberger asked you whether or not funding for the payment safeguard program was a problem for the agency, you answered that "there is a lot of pressure on the budget, without question. But we find that even in this atmosphere, we have been able to get the job done."

Now I realize that the backlogs which GAO describes accumulated before you became in charge of the agency. But wouldn't you say that these kind of backlogs are inconsistent with "being able to get the job done?"

Answer. In past years HCFA had requested additional safeguard funds. However, approval of the funds had been constrained by Congressionally-mandated deficit reduction measures and pre-established budget targets.

HCFA developed a backlog reporting and tracking system to insure these claims would not be forgotten and would be developed as soon as funds became available. In Fiscal Year 1992, the funds became available and the backlogs have been significantly reduced.

In addition, HCFA developed the IRS/SSA/HCFA Data Match. The initial tax years of the Data Match project are 1987–1989. Through the Data Match, HCFA is securing employment information to determine health insurance coverage on the employees of between 800,000 to 1,000,000 employers. Once the information is received, HCFA will take steps to stop payment on claims for beneficiaries who currently have employer coverage. HCFA will also search paid claim files to determine if mistaken payments have been made in the past where there was employer coverage.

The two actions mentioned above have enabled HCFA to "get the job done" through the lean years without losing track of the prior mistaken paid claims.

Question No. 2. GAO has testified that the budget for payment safeguard activities was cut between 1989 and 1992. You have testified that you are proposing about a 20% increase for 1993, relative to 1992. If this money were appropriated, can you assure us that the entire backlog that GAO reported for the Medicare secondary payment program will be eliminated?

Answer. The 20 percent increase in payment safeguard funds will eliminate the backlogs cited by the General Accounting Office. The only potential backlog that could occur would be from a higher than anticipated workload created by the IRS/SSA/HCFA Data Match.

Question No. 3. By your own testimony, you have indicated that each dollar spent on payment safeguards will yield a $15 return to the HI Trust Fund. In view of this extremely high rate of return, wouldn't a funding increase for FY 1993 of significantly more than the 20% that you have asked for be justified?

Answer. The current funding level is sufficient for all anticipated workloads for the Medicare contractors in Fiscal Year 1993. In addition, contingency funds released in Fiscal Year 1992 allowed HCFA to accelerate the recovery of prior mistaken payments.

From October 1991 to March 1992 Medicare fiscal intermediaries recovered over $112 million, and Medicare carriers recovered over $14 million in mistaken payments relating to claims that had previously been backlogged. Final resolution of many other backlogged claims was achieved by the contractors.

COMMUNICATIONS

STATEMENT OF THE COUNCIL OF NURSING HOME SUPPLIERS

Mr. Chairman, my name is Neal Thrift. I am Vice President of Care Supply, Inc., a nursing home supply company, and Chairman of the Council of Nursing Home Suppliers.

We applaud you, Senator Rockefeller, for your interest and dedication to health care and the Medicare program. Your hearing is viewed by our Council as an opportunity to seek change in an antiquated Medicare system which invites fraudulent practices.

CNHS is a newly formed organization, roughly a year old. Our members provide services to more than 100,000 nursing home residents in over 40 states. The Council's goal is to achieve a "level playing field"—both for Medicare beneficiaries and for suppliers of Medicare covered services. Currently, even though Medicare beneficiaries all pay the same monthly Part B premium, they are entitled to receive very different amounts and types of Medicare-covered supplies. Suppliers also receive widely varying payments for the same Medicare-covered products, inviting unscrupulous suppliers to "forum shop" for the highest paying Medicare carrier. To achieve this "level playing field" for both beneficiaries and suppliers, the Council advocates four program changes: (1) national uniform coverage guidelines for Medicare supplies; (2) national uniform utilization screens for Medicare-covered supplies; (3) national uniform reimbursement rates under the Medicare Part B program, and (4) public disclosure to beneficiaries and providers of these changes.

The types of products covered by Medicare, the number of products which Medicare will cover (called "utilization"), the medical criteria used by the carrier to qualify for the product, the amount of reimbursement for each product and the disclosure of information (and "utilization") are not uniform throughout the country. Instead, all these decisions are individually made by each of the more than 40 carriers—large insurance companies who contract with the Department of Health and Human Services to process and pay Medicare claims. Each carrier has jurisdiction over one or more states, so that if a carrier decides not to cover a certain product (or to reduce or limit the utilization of a covered product), all nursing home residents who live in the state or states over which the carrier has jurisdiction would be denied Medicare coverage for that product—if the claim is submitted to that carrier.

Not just coverage and utilization widely vary from carrier to carrier. Allowable charges also greatly vary from carrier to carrier, creating an incentive to abuse the system by billing the carrier that permits the highest reimbursement. Where two carriers serve a single state, coverage and utilization, as well as reimbursement often vary even within that single state. Although allowable charge information is available from most carriers, complete coverage criteria and utilization screens are not published and are generally unobtainable.

Congress took an important first step toward national rates in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) by adopting legislation to move to regional reimbursement rates by 1994. This legislation will achieve uniformity of reimbursement within each region for prosthetic devices and orthotics and prosthetics. However, this action will only result in uniform rates within each region. CNHS urges Congress to take the next step, and move to mandate uniform rates *nationwide.*

Moreover, mandating national reimbursement rates for prosthetic devices is consistent with the Congress's earlier move to national fee screens for parenteral and enteral nutrition (PEN) supplies, and the transition to "national" payment rates with regional variations for durable medical equipment ("DME"). Since CNHS members market nationally, CNHS members favor the adoption of national fee screens, similar to PEN reimbursement, rather than the DME model. Although DME reim-

bursement is moving to "national" payment rates, this system does not have truly national uniform payment rates, because the rates reflect some regional variations.

In addition to and consistent with mandating national uniform payment rates, the number of carriers should be reduced to the minimum necessary to efficiently process claims for Medicare Part B products and services furnished to nursing home residents. Congressionally mandated national uniform payment rates, and national uniform coverage and utilization screens, together with a reduction in the number of carriers would eliminate all incentive to "forum shop" and truly solve the problem that "zip code billing" by itself addresses without regard to its harmful impact on beneficiaries.

Senator Sasser's legislation, S. 1736, begins to address the problem of forum shopping with a provision which would move towards national uniform reimbursement rates. The Council supports this provision.

However, national uniform payment rates alone without national uniform coverage and utilization screens would discriminate against many Medicare beneficiaries. For example, although the payment rate for a particular item may be $10.00 nationwide, one carrier may decide that the item should not be covered at all, another carrier may decide that the utilization is two items per month per patient, and a third carrier may decide that the utilization is four. This is nonsense. Clearly, there is a need for uniform coverage and utilization rates, as well as uniform payment rates. As discussed above, the uniformity in coverage and utilization must apply nationwide. This is only common sense since all Medicare beneficiaries pay the some monthly premium—$31.80—for Part B services nationwide.

Moreover, uniform coverage and utilization must be adopted together. Legislation introduced by Senator Cohen, S. 1988 and by Rep. Pickle, H.R. 3837, would mandate national uniform coverage and utilization guidelines. Without uniform utilization guidelines, uniform coverage can be rendered meaningless. It is a cruel but simple ploy to say that a medically necessary product is "covered" by Medicare but then make the utilization of that product—the number and amount or preexisting medical condition so restrictive as to deprive Medicare beneficiaries of any real treatment or benefit.

The Council supports legislation mandating national uniform coverage for Medicare Part B supplies to nursing home patients. But it also believes that uniform coverage does not go far enough. The Council strongly urges Congress to take further steps to protect beneficiaries—and to mandate uniform utiltzation screens for covered products and services nationwide. CNHS also advocates that these national uniform utilization screens be adopted based on what is medically appropriate as determined by a panel of medical experts and disclosed to the medical community.

Currently, there are two proposals in the Senate, S. 1736 introduced by Senator Jim Sasser, and S. 1988, introduced by Senator William Cohen. Both address ideas that the Council supports: zip code billing and a reduction in the number of carriers from more than 40 to 4. However, these ideas will only begin to eliminate the problems of fraud and abuse. They will not completely eliminate the incentives for the unscrupulous to abuse the system and will harm beneficiary access to services. Nor will they eliminate abuse of beneficiaries and providers by Medicare carriers. Although the Council supports both bills and believes they should be incorporated into one comprehensive piece of legislation, we need to stress that unless uniform coverage, utilization and reimbursement are implemented simultaneously with zip code billing and a reduction in the number of carriers, the beneficiaries will be denied products and services in some states that will be covered in other states.

Another issue that has been raised is the ability of a supplier to obtain multiple provider numbers. A provider number is essentially an account number that enables a carrier to issue payment to a particular Medicare supplier. What has occurred, in some instances, is that a supplier will create several businesses and request separate provider numbers. At present, some provider number applications require the applicant to: (1) identify any owner or key employee of the business who has ever participated in the Medicare program; (2) state whether the supplier has more than one location; and (3) state whether the supplier serves beneficiaries in any other states. If a supplier deliberately fails to disclose other relationships, the supplier may be guilty of filing a false statement—a crime under federal law.

The council supports the provisions in the Cohen bill which would require the Secretary of HHS to: (1) develop national uniform standards for the application and issuance of provider numbers, (2) require the renewal of provider numbers, and (3) establish disclosure requirements in order to receive or renew a provider number. The Council believes the provisions in S. 1988 will go farther to eliminate fraud by imposing stricter standards on suppliers.

The Council of Nursing Rome Suppliers recommends that Congress require the Health Care Financing Administration (HCFA) to adopt one national uniform pro-

vider number application form for all Part B providers. Before a provider number is issued, the applicant would be required to disclose, under oath, on the form: (1) whether the supplier has more than one location; (2) all States in which the supplier serves Medicare beneficiaries; and (3) any other Medicare provider or supplier in which the applicant making disclosure or a family member has a controlling interest or ownership interest of 5% or more.

Recent media and Congressional attention has also focused upon suppliers increasing their reimbursement by billing Medicare for each individual component separately when, in fact, the supplier has delivered a kit or box of products to a nursing home resident. CNHS members are not aware of the facts in each of these cases, and cannot determine whether the supplier had actually been instructed by a particular carrier to bill per item or per component. For example, in 1990, some carriers issued written directions to suppliers to bill ostomy and urological items on a "per item" basis, not "per box" or "per package." Billing per item is consistent with the HCPCS codes, HCFA's national coding system for products which assigns allowable charges to individual items, not to packages or boxes of items. With regard to kits, some carriers issued written directions to suppliers to bill catheter care kits on an individual component basis after April 1, 1989.

Nevertheless, CNHS believes that where multiple items are delivered to a nursing home resident in a kit, Medicare should not reimburse on a component basis if this results in a greater reimbursement than is paid for the kit. To address this problem, CNHS recommends that Medicare adopt a national policy to reimburse suppliers an amount which equals the lesser of either the kit or the sum of its individual components.

RECOMMENDATIONS

CNHS recommends that a level playing field be created for both Medicare beneficiaries and Medicare Part B suppliers by mandating the following:

1. Congress should mandate the creation of payment rates, coverage determinations and utilization screens that are uniform nationwide for prosthetic devices, orthotics and prosthetics, and surgical dressings furnished to nursing home residents under Medicare Part B. Congress should go beyond current legislative proposals which mandate national uniform coverage and give Medicare beneficiaries additional protection and assurance of equal treatment by mandating national uniform utilization screens as well—with the medically appropriate screens to be determined by a panel of medical experts.
2. Congress should require full disclosure of payment rates, coverage guidelines and utilization screens along with information used to make such determinations to hold the program accumulate for their decisions and to prevent Medicare program abuse of beneficiary rights.
3. Consistent with the move to national uniform payment rates as a solution to "forum shopping," Congress should reduce the number of carriers to the minimum number necessary to efficiently process claims for orthotics, prosthetics, prosthetic devices and surgical dressings.
4. Congress should require that all carriers adopt a uniform provider number application form which provides for disclosure of interrelated ownership.
5. Congress should require carriers to reimburse suppliers an amount which is the lesser of either the cost of a kit as a whole or the total cost of the individual components.

CONCLUSION

Mr. Chairman and Committee members, we thank you for the opportunity to present our views. As our testimony notes, we seek to change the system which invites abuse, and we are always willing to work with your staff to develop legislation along the lines suggested in our testimony. The Council of Nursing Home Suppliers believes if Senator Sasser's and Senator Cohen's legislation were to be combined, our recommendations would be almost fulfilled.

STATEMENT OF THE NATIONAL ASSOCIATION OF MEDICAL DIRECTORS OF RESPIRATORY CARE

The National Association of Medical Directors of Respiratory Care (NAMDRC) welcomes the opportunity to submit comments in conjunction with the Senate Finance Subcommittee on Medicare and Long-Term Care hearings on ways to cut inappropriate Medicare spending.

NAMDRC's membership is composed of physicians in nearly 2,000 hospitals nationwide who serve as medical directors of respiratory care departments. Our primary responsibilities are to assist the hospital in the management of patients with respiratory problems, a significant portion of whom are on life support systems in intensive care units.

Much has been stated during hearings in both the House and Senate on the issue of physician referrals to entities in which they have an ownership interest. In fact, the Congress responded to evidence of abuses in the clinical laboratory arena by establishing a formal ban. We strongly support such bans when there is evidence of such abuse.

As medical directors we are intimately involved with the discharge of patients from hospitals who may need supplementary oxygen, home ventilators, or related equipment. Under current Medicare statute and regulations, we are required to complete a detailed "certificate of medical necessity" for such patients, identifying specific *objective medical criteria* such as arterial blood gas results or oxygen saturation measurements. These specific measurements were identified as benchmarks by a national institutes of health consensus conference on long term oxygen therapy and are strongly supported by the medical community as accurate indicators to identify patients who genuinely need supplementary oxygen.

Additionally, it is important to recognize that Medicare payment of oxygen, a therapeutic modality, is *not* dependent upon the supplier. Rather, it is a flat payment regardless of the supplier. If a physician refers a patient to company A or company B, the payment by Medicare is the same.

Therefore, NAMDRC believes that it is reasonable to provide an exemption relative to a ban on physician referrals to entities in which they have an ownership interest when the department of health and human services requires objective medical criteria to determine the therapeutic need for a reimbursable item such as oxygen.

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